COMMONWEALTH of VIRGINIA

Department for the Aging

Jay W. DeBoer, J.D., Commissioner

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AAA TUESDAY MAILING
November 18, 2003

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Virginia department for the Aging

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: November 18, 2003

SUBJECT: **GOVERNOR'S 'PROTECT & RESPECT' PROGRAM FUNDS LOCAL ELDER SAFETY PROJECTS STATEWIDE**

Sixteen community, faith-based, law enforcement, school, and senior service organizations, including two Area Agencies on Aging, have been awarded more than a half-million dollars in grants as part of the Governor's "Protect and Respect Program," an intergenerational safety and awareness initiative for older Virginians launched last May. The Protect and Respect Program encourages all of Virginia's citizens, especially young people, to understand the importance of safeguarding our older citizens, and taking individual efforts to ensure their protection.

The selected Area Agencies on Aging were screened by a peer review panel of experts in youth and senior programs, including staff from VDA, and they were chosen based upon their program design's adherence to the criteria of the federal Department of Education's Safe and Drug-Free Schools and Communities Act Program (SDFSC):

- A $50,000 grant to **Senior Connections: The Capital Area Agency On Aging** of Richmond to fund the Senior Commitment To Youth Project, a mentoring program that will expand on its Foster Grandparent and Volunteer Program working with at-risk children from 6 to 12 years-of-age.

- A $10,000 grant to The **Appalachian Agency For Senior Citizens** to implement the Teens, Crime And The Community Curriculum among students who also will study computer crime prevention strategies and then provide this information to seniors at the local Area Agency on Aging.

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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Marsha Mucha
Administrative Staff Assistant

DATE: November 18, 2003

RE: Commonwealth Council on Aging Meeting Dates

The next meeting of the Commonwealth Council on Aging will be held on December 4, 2003.

The Council will meet on the following dates in 2004:

- Wednesday, January 28 * (meeting begins at 11:00 a.m.)
- Thursday, May 27
- Thursday, September 9
- Thursday December 2

All meetings will be held at the Virginia Department for the Aging and will begin at 10:00 a.m. Public comments are welcomed.

If you have any questions or would like additional information, please contact Marsha Mucha at (804) 662-9312.

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COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen M. Nau, Human Services Program Coordinator

DATE: November18, 2003

SUBJECT: Kinship Care

A limited quantity of **IRS Brochures**, Advanced Earned Income Tax Credit and The Earned Income Tax Credit are now available from VDA for your kinship care groups. Relative caregivers of children reporting certain earned income and adjusted gross income of certain levels may be eligible to claim tax credit on their tax returns. Please email Ellen Nau at **Enau@vdh.state.va.us** to obtain copies of these two brochures.

The National Children's Center for Rural and Agricultural Health and Safety announces a Mini Grant Program to support small-scale projects and pilot studies that address prevention of childhood agricultural disease and injury. A maximum of $15,000 may be requested. It is anticipated that four grants will be awarded. For further information, contact the organization's website at **http://research.marshfieldclinic.org/children/specialProjects2004.htm**.

Relatives caring for children in the Southeastern Region of Virginia may find valuable resources at the **Kids Priority One** website sponsored by the Kiwanis Children's Council of Hampton Roads. The online resource center is the result of collaboration effort between representatives of local Kiwanis clubs and public and private organizations. Information can be found at **info@kidsprioritytone.org** or KidsPriorityOne 1900 Llewellyn Avenue Norfolk, VA 23517 or Phone: 757-CHILDREN.

The latest Generations United Newsletter, Volume 8, Number 4, 2003, ***Together***, offers many ideas on funding intergenerational programs. Generations United can be contacted at 202-638-1263 or at the organization's website, **www.gu.org**.

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Carol Cooper Driskill

DATE: November 18, 20003

SUBJECT: A New Talking Web Site for Seniors: NIHSeniorHealth.gov

The National Institute on Aging and the National Library of Medicine, both part of the National Institutes of Health (NIH), have developed a website focusing on aging-related health issues for adults 60 and older. View the new site at: http://nihseniorhealth.gov/.

This new talking web site has formats and topics tailored to the needs of older people. The senior friendly site takes advantage of techniques developed by the National Institute on Aging (NIA) and the National Library of Medicine (NLM) to encourage older people to use the Internet, and this site in particular, as a resource for the best information on health and medical research.

"The way in which people think, learn, and remember, changes with age," says Dr. Richard J. Hodes, director of the NIA. "This new web site is based on the latest research on cognition and aging . . ." "The use of the Internet for health information is increasing dramatically," notes Dr. Donald A.B. Lindberg, director of the NLM. "But the small type, low contrast, and difficulty in navigating around many sites have been obstacles for seniors." This site corrects many of those problems and provides health information that "is the best that NIH can offer."

The NIA and NLM brought together researchers who study cognition, web site designers, and communications experts to design a site that is easy for older adults to read, understand, remember, and navigate. For example, the site features large print and short, easy-to-read segments of information repeated in a variety of formats to increase the likelihood it will be remembered. Consistent page layout and prompts help older adults move from one place to

another on the site. Each topic provides general background information, quizzes, frequently asked questions, open-captioned video clips, transcripts, photos and illustrations.

NIHSeniorHealth.gov has a "talking" function, which allows users the option of reading the text or listening to it as it is read to them. Finally, the new site complies with Section 508 of the Rehabilitation Act of 1973, making it accessible for persons with disabilities.

Since the risk of many diseases increases with age, the site focuses on health topics or specific diseases that are of particular interest to older people. Examples include: Alzheimer's disease, care giving, arthritis, balance problems, colorectal cancer, exercise for older adults, and hearing loss. In coming months, topics will include complementary and alternative medicine, diabetes, falls, vision changes, and others.

NIHSeniorHealth.gov is expected to serve as a model for web designers seeking to make sites accessible for older adults. The NIA and NLM have developed a booklet, *Making Your Web Site Senior Friendly: A Checklist*, which gives guidelines that can be used to update any web site with cognitive aspects of aging in mind.

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Carol Cooper Driskill

DATE: November 18, 2003

SUBJECT: **Communicating With Clients in Person and Over the Phone**

Communicating With Clients in Person and Over the Phone is an interesting article published by The Center for Medicare Education. I found it useful and informative for anyone who communicates with clients, whether in person or over the telephone. The brief contains information about improving communication with older adults, and discusses more than just Medicare. There are also resources at the end of the article.

The article discusses:

- Oral communication
- Why certain topics are hard to talk about
- Factors that interfere with communication
- How people learn
- How to confirm understanding
- Strategies to communicate in ways the client can understand

You can read the article at http://www.medicareed.org/content/CMEPubDocs/V4N8.pdf

There is more than one "right" way to communicate! I have provided an outline of the brief on the next page.

Communicating With Clients in Person and Over the Phone
CENTER FOR MEDICARE EDUCATION
Issue Brief Vol.4 No.8

Possible Reasons for Communication Difficulties:

Types of information
Words, terms and acronyms
Distractions
Disability
Culture
Amount of information
Emotions
Age
Language
Limited literacy skills

Communicating Over the Telephone:

Choose your words carefully
Have help in your voice
Take responsibility for the direction of the conversation
Confirm understanding

Communicating in Person:

Establish environment conducive to learning
Use a positive & supportive approach
Organize your message to get the point across
Choose your words carefully
Adjust your teaching to accommodate a person's learning style & special needs
Ask client to bring family member or friend to your meeting
Verify understanding

Communicating with People who are Deaf or Hard of Hearing:

It takes significant concentration to read lips or speech
Find out specific things you can do
Get the person's attention
Articulate clearly and speak in natural tones
Make sure you can be clearly seen
Reduce distracting/ interfering sounds
Confirm understanding

Communicating with People who are Blind or Have Low Vision:

Introduce yourself & others
Use everyday words
Ask if the person wants assistance
Provide clear directions

Communicating with People who Speak English as a Second Language

Where is client along language continuum?
State the message clearly & simply
Supplement the spoken word
Pay attention to nonverbal communication
Concentrate on most important message
Use a trained medical interpreter
Work with family decision maker
Verify the patient's understanding

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim M. Catherman
Deputy Commissioner, Support Services

DATE: November 18, 2003

SUBJECT: Federal NAPIS–SPR Public Comment (Second Round)

On Tuesday, November 4, 2003, the Administration on Aging (AoA) placed notice in the Federal Register to solicit comments on the revised NAPIS-SPR report. A copy of the additional revisions is attached. Comments will be accepted through December 4, 2003. Send comment to:

Office of Information and Regulatory Affairs, OMB
New Executive Office Building
725 17th Street, NW, Room 10235
Washington, DC 20503
Attn: Brenda Aguilar, Desk Office for AoA

The Department will be making public comment. We invite you to make public comment also.

If you have any questions, please call me at (804) 662-9309.

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Reporting Requirements
For Title III and VII

Of the Older Americans Act
(Not including LTC Ombudsman Program)
For FY '05 and Subsequent Years

Title III and VII State Program Report Data Elements
State Program Report Transmittal Requirements
State Program Report Definitions

Administration on Aging
U.S. Department of Health and Human Services
September 26, 2003

Overview of Title III and VII State Performance Reporting Requirements

In the 2000 reauthorization of the Older Americans Act, the Administration on Aging (AoA) was instructed to use, to the maximum extent possible, the data collected by State agencies, area agencies on aging, and service providers through the National Aging Program Information System (NAPIS) and other applicable sources of information in the development of performance measures, and in compliance with the Government Performance and Results Act of 1993.

The Assistant Secretary for Aging was also instructed to annually report to the President and to the Congress on the activities carried out under the Older Americans Act. This report includes (section 207 (3)) *statistical data and an analysis of information regarding the effectiveness of the State agency and area agencies on aging in targeting services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals, older individuals residing in rural areas, low-income individuals, and frail individuals (including individuals with any physical or mental functional impairments).*

As a response to these mandates, AoA is issuing revised reporting guidelines for Titles III and VII. These OMB approved reporting requirements are a revision of those which are currently in effect. The factors which influenced the revision of the SPR, include: 1) the need to develop more permanent information requirements for the National Family Caregiver Support Program; 2) the need to comply with revised OMB standards for gathering information regarding race and ethnicity; 3) the need to reduce the burden of the SPR/NAPIS requirements on States, area agencies and service providers; and 4) the need to consider the collection of alternative data elements to reflect Network performance.

This document summarizes the requirements for the State Program Performance Report (SPR) for Titles III and VII for fiscal year 2004 (FY04) and subsequent years by all State units on aging. The sections of the SPR include:

Section I. Elderly Clients and Caregivers

A. Elderly Client Counts
B. General Characteristics of Elderly Clients Receiving Registered Services and those Receiving Cluster 2 Registered Services
C. Detailed ADL Characteristics of Elderly Clients Receiving Cluster 1 Services
D. Detailed IADL Characteristics of Elderly Clients Receiving Cluster 1 Services
E. Summary Characteristics of Caregivers Serving Elderly Individuals (National Family Caregiver Support Program – Title III-E)
F. Summary Characteristics of Grandparents and Other Elderly Caregivers Serving Children (National Family Caregiver Support Program – Title III-E III-E)

Section II. Utilization and Expenditure Profiles

A. Title III Utilization and Expenditure Profile (except Title III-E)
B. Title III-E Utilization and Expenditure Profile For Caregivers Serving Elderly Individuals
C. Title III-E Utilization and Expenditure Profile For Grandparents and Other Elderly Caregivers Serving Children
D. Title VII Expenditures by Chapter (Except Chapter 2. Ombudsman)
E. Other Services Profile *(Optional)*

Section III. Network Profiles

A. State Unit on Aging Staffing Profile
B. Area Agency on Aging Staffing Profile
C. Provider Profile (excluding AAAs providing direct services)
D. Profile of Community Focal Points and Senior Centers

Section IV. Developmental Accomplishments

A. For Home and Community Based Programs
B. For A System of Elder Rights

On the following pages, the SPR format is exhibited through a series of data tables corresponding with the sections of the SPR listed above. The tables are for presentation purposes only. AoA will continue to require electronic transmittal of the annual SPR data. The feasibility of internet based reporting is also being considered.

SECTION I. Elderly Clients and Caregivers

A. Elderly Client Counts

State ID: ____
Fiscal Year: ____

	Total
1. Unduplicated Count of Persons Served For Registered Services Supported by the OAA Title III	
2. Estimated* Unduplicated Count of Persons Served For Unregistered Services Supported by the OAA Title III	
3. Total Estimated Unduplicated Count of Persons Served Through Services Supported by OAA Title III	

* There is no prescribed method for developing this estimate.

SECTION I. Elderly Clients and Caregivers

B. General Characteristics of Elderly Clients Receiving Registered Services and Those Receiving Cluster 2 Registered Services (FY05 Implementation)

State ID: ____ Fiscal Year: ____

___ Total Registered Clients (Cluster 1 and Cluster 2) **___ Congregate Meals** **___ Nutrition Counseling** **___ Assisted Transportation**

	Clients Receiving Registered Services*				
	Total*	With Income Below Poverty	Age of Client		
			60-74	75-84	85+
Total Clients					
Total with Age Reported					
Age Missing					
Female					
Male					
Gender Missing					
Rural Clients					
Rural Missing					
Poverty Missing					
Live Alone					
Live Alone Missing					
Clients By Ethnicity					
Hispanic or Latino					
Not Hispanic or Latino					
Ethnicity Missing					
Clients By Race or Ethnicity					
White (Alone) – Non-Hispanic					
Total Minorities					
White (Alone) - Hispanic					
American Indian or Alaska Native (Alone)**					
Asian (Alone)					
Black or African American (Alone)					
Native Hawaiian or Other Pacific Islander (Alone)					
Persons Reporting Some Other Race					
Persons Reporting 2 or More Races					
Race Missing					

NOTE: States are no longer required to report Unduplicated Client Counts By Characteristic for Unregistered Services.
States are required to report unduplicated client counts by characteristic for all registered services.
Registered services include: Personal Care, Homemaker, Chore, Home Delivered Meals, Adult Day Care/Health, Case Management, Assisted Transportation, Congregate Meals, and Nutrition Counseling.
*** Total clients includes OAA specified eligible meal participants under age 60.**
****"(Alone)" – when appended to a racial category - means that the individual designated only one race category.**

SECTION I. Elderly Clients and Caregivers

C. Detailed ADL Characteristics of Elderly Clients Receiving Cluster 1 Services

(Report information for all Cluster 1 services combined and each service separately.)

_____ **Total Cluster 1 Clients** _____ **Personal Care** _____ **Homemaker**
_____ **Chore** _____ **Home Delivered Meals** _____ **Adult Day Care/Health**
_____ **Case Management**

ADL SUMMARY FOR _____	Total – All Ages*					Total Age 60-74					Total Age 75-84					Total Age 85+				
	Total	0 ADL	1 ADL	2 ADL	3+ ADL	Total	0 ADL	1 ADL	2 ADL	3+ ADL	Total	0 ADL	1 ADL	2 ADL	3+ ADL	Total	0 ADL	1 ADL	2 ADL	3+ ADL
Total Clients																				
Clients with Age Data																				
Age Missing																				
ADLs Missing																				
Female																				
Male																				
Gender Missing																				
Rural																				
Rural Missing																				
Income below Poverty Level																				
Poverty Missing																				
Live Alone																				
Live Alone Missing																				
Clients by Ethnicity																				
Hispanic / Latino																				
Not Hispanic or Latino																				
Ethnicity Missing																				
Clients by Race or Ethnicity																				
White (Alone) – Non-Hispanic																				
Total Minorities																				
White (Alone) - Hispanic																				
American Indian or Alaskan Native (Alone)																				
Asian (Alone)																				
Black / African American (Alone)																				
Native Hawaiian or Pacific Islander (Alone)																				
Persons Reporting Some Other Race																				
Persons Reporting 2 or More Races																				
Race Missing																				

*** Total includes OAA specified eligible meal participants under age 60.**

SECTION I. Elderly Clients and Caregivers

D. Detailed IADL Characteristics of Elderly Clients Receiving Cluster 1 Services

(Report information for all Cluster 1 services combined and each service separately.)

_____ Total Cluster 1 Clients **_____ Personal Care** **_____ Homemaker**

_____ Chore **_____ Home Delivered Meals** **_____ Adult Day Care/Health**

_____ Case Management

IADL SUMMARY FOR _____	Total – All Ages*					Total Age 60-74					Total Age 75-84					Total Age 85+				
	Total	0 IADL	1 IADL	2 IADL	3+ IADL	Total	0 IADL	1 IADL	2 IADL	3+ IADL	Total	0 IADL	1 IADL	2 IADL	3+ IADL	Total	0 IADL	1 IADL	2 IADL	3+ IADL
Total Clients																				
Clients with Age Data																				
Age Missing																				
IADLs Missing																				
Female																				
Male																				
Gender Missing																				
Rural																				
Rural Missing																				
Income below Poverty Level																				
Poverty Missing																				
Live Alone																				
Live Alone Missing																				
Clients by Ethnicity																				
Hispanic / Latino																				
Not Hispanic or Latino																				
Ethnicity Missing																				
Clients by Race or Ethnicity																				
White (Alone) – Non-Hispanic																				
Total Minorities																				
White (Alone) - Hispanic																				
American Indian or Alaskan Native (Alone)																				
Asian (Alone)																				
Black / African American (Alone)																				
Native Hawaiian or Pacific Islander (Alone)																				
Persons Reporting Some Other Race																				
Persons Reporting 2 or More Races																				
Race Missing																				

*** Total includes OAA specified eligible meal participants under age 60.**

Section I. Elderly Clients and Caregivers

E. Summary Characteristics of Caregivers Serving Elderly Individuals (National Family Caregiver Support Program - Title III-E)

Note: Data is for Title III-E Cluster 1 Services only – See Section II-C for specifics. (FY05 Implementation)

State ID: ____ Fiscal Year: ____

Caregiver Characteristics	All Caregivers	Age of the Caregiver			
		Under 60	Age 60-74	Age 75-84	Age 85 +
Total Caregivers					
Caregivers with Age Data					
Age Missing					
Female					
Male					
Gender Missing					
Rural					
Rural Missing					
Caregivers by Ethnicity					
Hispanic or Latino					
White (Alone) – Non-Hispanic					
Total Minorities					
White (Alone) –Hispanic					
Asian (Alone)					
Am. Ind./Alaska Native (Alone)					
Black or African American (alone)					
Native Hawaiian or Other Pacific Islander (Alone)					
Persons Reporting Some Other Race					
Persons Reporting 2 or More Races					
Race Missing					
Caregivers by Relationship					
Husband					
Wife					
Son/*Son-in-Law*					
Daughter/*Daughter-in-law*					
Other Relative					
Non-Relative					
Relationship Missing					

SECTION I. Elderly Clients and Caregivers

F. Summary Characteristics of Grandparents and Other Elderly Caregivers Serving Children (National Family Caregiver Support Program - Title III-E)

Note: Data is for Title III-E Cluster 1 Services only – See Section II-C for specifics.

Grandparent/Relative Caregiver Characteristics	All Caregivers			
		Age of the Caregiver		
		60-74	75-84	85+
Total Caregivers				
Caregivers with Age				
Age Missing				
Female				
Male				
Gender Missing				
Rural				
Rural Missing				
Caregivers by Ethnicity				
Hispanic or Latino				
Not Hispanic or Latino				
Ethnicity Missing				
Caregivers by Race or Ethnicity:				
White (Alone) – Non-Hispanic				
Total Minorities				
White (Alone) - Hispanic				
Asian (Alone)				
American Indian/Alaska Native (Alone)				
Black or African American (Alone)				
Native Hawaiian or Other Pacific Islander (Alone)				
Persons Reporting Some Other Race				
Persons Reporting Two or More Races				
Race Missing				
Caregivers By Relationship				
Grandparents				
Other Elderly Relative				
Other Elderly Non-Relative				
Relationship Missing				
Total Individuals Receiving Care (children 18 or younger)				

SECTION II. Utilization and Expenditure Profiles
A. Title III Utilization and Expenditure Profile (Except Title III-E)
State ID____ Fiscal Year: _____

A. Title III Utilization and Expenditure Profile (Except Title III-E)									OAA Title III Expenditures ($) by Part			
For Selected Services	Number of Providers	# of AAAs Direct Services Provision	Unduplicated Persons Served	# of Persons Served at High Nutrition Risk	Service Units	Title III Expenditure	Total Service Expenditure	Program Income	B	C1	C2	D
Cluster 1: Registered Services - Requiring Detailed Client Profile												
1. Personal Care												
2. Homemaker												
3. Chore												
4. Home Delivered Meals												
4a. NSIP Home Delivered Meals (optional)*												
5. Adult Day Care/Health												
6. Case Management												
Cluster 2: Registered Services - Requiring Summary Client Profile												
7. Assisted Transportation												
8. Congregate Meals												
8a. NSIP Congregate Meals (optional)*												
9. Nutrition Counseling												
Cluster 3: Non-Registered Services – No Client Profile Required												
10. Transportation												
11. Legal Assistance												
12. Nutrition Education												
13. Information and Assistance												
14. Outreach												
15. Other Services												
Total (Unduplicated)												

Note: States are to report Title III-E in the next table: Section II. B-Title III-E Caregiver Utilization and Expenditure Profile
**** States may opt to report separate NSIP meal counts (items 4a and 8a) if different from the regular SPR numbers. If no NSIP number is reported, AoA will use the regular SPR figures (4 and 8).*** **See definition in the Appendix.**

Section II. Utilization and Expenditure Profiles

B. Title III-E Utilization and Expenditure Profile for Caregivers Serving Elderly Individuals

Caregiver Support Categories:	Title III-E Expenditures (Federal $)	Total Service Expenditures (All Sources)	Program Income	# Caregivers Served	Units of Service	# of Providers (unduplicated)
Group 1				**Unduplicated number of caregivers:**		
1. Counseling						
2. Respite Care						
3. Supplemental Services						
Group 2				**Estimated unduplicated number of caregivers:**		
4. Access Assistance						
				Estimated Audience size:	**# Activities:**	
5. Information Services						
Totals (unduplicated)						

Section II. Utilization and Expenditure Profiles

C. Title III-E Utilization and Expenditure Profile For Grandparents and Other Elderly Caregivers Serving Children

Caregiver Support Categories:	Title III-E Expenditures (Federal $)	Total Service Expenditures (All Sources)	Program Income	# Caregivers Served	Units of Service	# of Providers (unduplicated)
Group 1				**Unduplicated number of caregivers:**		
1. Counseling						
2. Respite Care						
3. Supplemental Services						
Group 2				**Estimated unduplicated number of caregivers:**		
4. Access Assistance						
				Estimated Audience size:	**# Activities:**	
5. Information Services						
Totals (unduplicated)						

SECTION II. Utilization and Expenditure Profiles

D. Title VII Expenditures by Chapter

C. Title VII Expenditures By Chapter	Title VII Expenditure	Total Service Expenditure
Chapter 3: Elder Abuse Prevention		
Chapter 4: Legal Assistance Development		

Note: OAA Title VII, Chapter 2, Ombudsman expenditures are reported separately in the National Ombudsman Reporting System (NORS).

SECTION II. Utilization and Expenditures Profiles

E. Other Services Profile *(Optional)*

State ID: ____ Fiscal Year: ____

Service Name (Up to 30 Characters)	Service Unit Name (Up to 15 characters)	Mission/ Purpose Category	OAA Service Expenditure Amount	Total Service Expenditure Amount	Estimated Unduplicated Persons Served	Estimated Service Units
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Mission/Purpose Codes:
A. Services which address functional limitations
B. Services which maintain health
C. Services which protect elder rights
D. Services which promote socialization/participation
E. Services which assure access and coordination
F. Services which support other goals/outcomes

There are no restrictions on the number of “other” services that may be reported.

For each “other” service being reported, please provide all the data elements—name, unit name, mission code, expenditure data, persons served, and service units.

SECTION III. Network Profiles

A. State Unit on Aging Staffing Profile

State ID: ____ **Fiscal Year: ____**

SUA Personnel Categories	Total FTEs	Minority FTEs
1. Agency Executive/ Management Staff		
2. Other Paid Professional Staff (By Functional Responsibility)		
A. Planning		
B. Development		
C. Administration		
D. Service Delivery		
E. Access/Care Coordination		
F. Other		
3. Clerical/Support Staff		
4. Total SUA Staff		

Functional Responsibilities:
A. Planning—Includes needs assessment, plan development, budgeting/resource analysis, service inventories, standards development and policy analysis.
B. Development—Includes public education, resource development, training and education, research and development and legislative activities.
C. Administration—Includes bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring and quality assurance.
D. Service Delivery—Includes those activities associated with the direct provision of a service which meets the needs of an individual older person and/or caregiver.
E. Access/Care Coordination—Include outreach, screening, assessment, case management and I&R.

SECTION III. Network Profiles

B. Area Agency on Aging Staffing Profile

State ID: ____ Fiscal Year: ____ Total # of AAA's _____

AAA Personnel Categories	Total FTEs	Minority FTEs
1. Agency Executive/ Management Staff		
2. Other Paid Professional Staff (By Functional Responsibility)		
A. Planning		
B. Development		
C. Administration		
D. Service Delivery		
E. Access/Care Coordination		
F. Other		
3. Clerical/Support Staff		
4. Volunteers		
5. Total AAA Staff		

Functional Responsibilities:
A. Planning—Includes needs assessment, plan development, budgeting/resource analysis, service inventories, standards development and policy analysis.
B. Development—Includes public education, resource development, training and education, research and development and legislative activities.
C. Administration—Includes bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring and quality assurance.
D. Service Delivery—Includes those activities associated with the direct provision of a service which meets the needs of an individual older person and/or caregiver.
E. Access/Care Coordination—Include outreach, screening, assessment, case management and I&R.

Section III. Network Profiles
C. Provider Profile (Excluding Area Agencies on Aging providing direct services)

	Total # of Providers
Total	
Minority	
Rural	

SECTION III Network Profiles
D. Profile of Community Focal Points and Senior Centers

State ID: ____ Fiscal Year: ____

	Number
1. Total Number of Focal Points Designated Under Section 306(a)(3) of the Act in Operation in the Past Year.	
2. Of the Total Number of Focal Points in Item 1., the Number That Were Senior Centers.	
3. Total Number of Senior Centers in the State in the Past Fiscal Year.	
4. Total Number of Senior Centers in Item 3. That Received OAA Funds During the Past Fiscal Year.	

SECTION IV. DEVELOPMENTAL ACCOMPLISHMENTS
a. FOR HOME AND COMMUNITY BASED PROGRAMS*

State ID: ____ Fiscal Year: ____

Identification Of Three Top Accomplishments		
1.		
	TYPE_CODE	**Enter Code(s)**
2.		
		Enter Code(s)
3.		
		Enter Code(s)

Development Type Codes:			
1. Public education/awareness	**3. Training/education**	**5. Policy development**	**7. Other**
2. Resource development	**4. Research and development**	**6. Legislative development**	

*** includes Title III-E NFCSP**

SECTION IV. DEVELOPMENTAL ACCOMPLISHMENTS
B. FOR A SYSTEM OF ELDER RIGHTS
State ID: ____ Fiscal Year: ____

Identification Of Three Top Accomplishments		
1.		
	TYPE_CODE	**Enter Code(s)**
2.		
		Enter Code(s)
3.		
		Enter Code(s)

1. Public education/awareness	**3. Training/education**	**5. Policy development**	**7. Other**
2. Resource development	**4. Research and development**	**6. Legislative development**	

Appendix -- Definitions

The following definitions should be used when completing the SPR:

A. Characteristics of Elderly Clients

Race/Ethnicity Status – The following reflects the requirements of the Office of Management and Budget (OMB) for obtaining information from individuals regarding race and ethnicity. It constitutes what OMB classifies as the "two-question format." When questions on race and ethnicity are administered, respondents are to be asked about their ethnicity and race as two separate questions. Respondents should ideally be given the opportunity for self-identification, and are to be allowed to designate all categories that apply to them. Consistent with OMB requirements, the following are the race and ethnicity categories to be used for information collection purposes:

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

American Indian or Alaskan Native—A person having origins in any of the original peoples of North America (including Central America), and who maintains tribal affiliation or community attachment.

Asian –A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam

Black or African American—A person having origins in any of the black racial groups of Africa.

Hispanic or Latino—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White – A person having origins in any of the peoples of Europe, the Middle East, or North Africa.

"(Alone)" – When appended to a racial category (e.g., "White (Alone)" means that the individual only designated one race category.

Impairment in Activities of Daily Living (ADL) --The inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking.

Impairment in Instrumental Activities of Daily Living (IADL) -- The inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance).

Poverty—Persons considered to be in poverty are those whose income is below the official poverty guideline (as defined each year by the Office of Management and Budget, and adjusted by the Secretary, DHHS) in accordance with subsection 673 (2) of the Community Services Block Grant Act (42 U.S.C. 9902 (2)). The annual HHS Poverty Guidelines provide dollar thresholds representing poverty levels for households of various sizes.

Living alone—A one person household (using the Census definition of household) where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting, including board and care facilities, assisted living units and group homes.

B. Characteristics of Individuals Associated with the National Family Caregiver Support Program (Title III-E. NFCSP)

Child—An individual who is not more than 18 years of age. The term relates to a grandparent or other older relative who is a caregiver of a child.

Caregiver—An adult family member or another individual, who is an "informal" provider of in-home and community care to an older individual. "Informal" means that the care is not provided as part of a public or private formal service program.

Grandparent or other older relative caregiver of a child –A grandparent, step grandparent or other relative of a child by blood or marriage, who is 60 years of age or older and—

(A) lives with the child;
(B) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and
(C) has a legal relationship to the child, as such legal custody or guardianship, or is raising the child informally.

Elderly Client – An eligible (60 years of age or older) elderly individual who receives OAA services.

C. Standardized names, definitions and service units are provided for the services that are singled out in the SPR for reporting

Personal Care (1 Hour) -- Personal assistance, stand-by assistance, supervision or cues.

Homemaker (1 Hour) -- Assistance such as preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.

Chore (1 Hour) -- Assistance such as heavy housework, yard work or sidewalk maintenance for a person.

Home-Delivered Meal (1 Meal)**--** A meal provided to a qualified individual in his/her place of residence. The meal is served in a program administered by SUAs and/or AAAs and meets all of the requirements of the Older Americans Act and State/Local laws. As noted in Section IIA, meals provided to individuals through means-tested programs such as Medicaid Title XIX waiver meals or other programs such as state-funded means-tested programs are excluded from the NSIP meals figure in line 4a; they are included in the meal total reported on line 4 of Section IIA. Certain Title III-E funded home delivered meals may also be included – see the definition of NSIP meals below.

Adult Day Care/Adult Day Health (1 hour) – Personal care for dependent elders in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health**.**

Case Management (1 Hour) -- Assistance either in the form of access or care coordination in circumstances where the older person is experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers or family caregivers. Activities of case management include such practices as assessing needs, developing care plans, authorizing and coordinating services among providers, and providing follow-up and reassessment, as required.

Congregate Meal (1 Meal) – A meal provided to a qualified individual in a congregate or group setting. The meal as served meets all of the requirements of the Older Americans Act and State/Local laws. As noted in Section IIA, meals provided to individuals through means-tested programs such as Medicaid Title XIX waiver meals or other programs such as state-funded means-tested programs are excluded from the NSIP meals figure in line 8a; they are included in the meal total reported on line 8 of Section IIA.

Nutrition Education (1 session per participant) -- A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietician or individual of comparable expertise.

Nutrition Counseling (1 session per participant) -- Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-on-one by a registered dietician, and addresses the options and methods for improving nutrition status.

High Nutritional Risk (persons) – An individual who scores six (6) or higher on the DETERMINE Your Nutritional Risk checklist published by the Nutrition Screening Initiative.

NSIP Meals (1 meal) -- A Nutrition Services Incentive Program (NSIP) Meal is a meal served in compliance with all the requirements of the OAA, which means at a minimum that: 1) it has been served to a participant who is eligible under the OAA and has NOT been means-tested for participation; 2) it is compliant with the nutrition requirements; 3) it is served by an eligible agency; and 4) it is served to an individual who has an opportunity to contribute. Meal counts in 4, 4a, 8, 8a, include all OAA eligible meals including those served to persons under age 60 where authorized by the OAA. NSIP Meals also include home delivered meals provided as Supplemental Services under the National Family Caregiver Support Program (Title III-E) to persons aged 60 and over who are either care recipients (as well as their spouses of any age) or caregivers.

Assisted Transportation (1 One Way Trip) -- Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.

Transportation (1 One Way Trip) – Transportation from one location to another. Does not include any other activity.

Legal Assistance (1 hour) -- Legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.

Information and Assistance (1 Contact) -- A service that: (A) provides individuals with information on services available within the communities; (B) links individuals to the services and opportunities that are available within the communities; (C) to the maximum extent practicable, establishes adequate follow-up procedures. Internet web site "hits" are to be counted only if information is requested and supplied.

Outreach (1 Contact) – Intervention with individuals initiated by an agency or organization for the purpose of identifying potential clients (or their care givers) and encouraging their use of existing services and benefits.

Note: The service units for information and assistance and for outreach are individual, one-on-one contacts between a service provider and an elderly client or caregiver. An activity that involves contact with multiple current or potential clients or caregivers (e.g., publications, publicity campaigns, and other mass media activities) should not be counted as a unit of service. Such services might be termed public information and reported on the public information category. They may also be reported in "Section II.E. – Utilization and Expenditures Profiles, Other Services Profile (Optional)."

Other Services – A service provided using OAA funds that do not fall into the previously defined service categories. States have the option of reporting such services in "Section II.E. – Utilization and Expenditures Profiles, Other Services Profile (Optional)." Expenditures on "Other Services" in Section II.A. Line 15 is required.

D. Services to Caregivers

Counseling --(1 session) Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families).

Respite Care --(1 hour) Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. Respite Care includes: (1) In-home respite (personal care, homemaker, and other in-home respite); (2) respite provided by attendance of the care recipient at a senior center or other nonresidential program; 3) institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver; and (for grandparents caring for children) summer camps. If the specific service units purchased via a direct payment (cash or voucher) can be tracked or estimated, report those service unit hours. If not, a unit of service in a direct payment is one payment.

Supplemental services –Services provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but are not limited to, home modifications, assistive technologies, emergency response systems, and incontinence supplies.

Information Services (1 activity) -- A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities. [Note: service units for information services are for activities directed to large audiences of current or potential caregivers such as disseminating publications, conducting media campaigns, and other similar activities.]

Access Assistance (1 contact) -- A service that assists caregivers in obtaining access to the services and resources that are available within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures. [Note: Information and assistance to caregivers is an access service, i.e., a service that: (A) provides individuals with information on services available within the communities; (B) links individuals to the services and opportunities that are available within the communities; (C) to the maximum extent practicable, establishes adequate follow-up procedures. Internet web site "hits" are to be counted only if information is requested and supplied.]

E. Other Definitions

A variety of other terms are used in the SPR. Definitions for these terms are as follows:

Legal Assistance Development - Activities carried out by the state "Legal Assistance Developer" that are designed to coordinate and enhance state and local legal services and elder rights programs.

Volunteer—An uncompensated individual who provides services or support on behalf of older individuals. Only staff working under the AAA, not the AAA contractors, shall be included.

Agency Executive/Management Staff—Personnel such as SUA director, deputy directors, directors of key divisions and other positions which provide overall leadership and direction for the state or area agency on aging.

Other Paid Professional Staff—Personnel who are considered professional staff who are not responsible for overall agency management or direction setting but carry out key responsibilities or tasks associated with the state or area agency the following areas:

Planning—Includes such responsibilities as needs assessment, plan development, budgeting/resource analysis, inventory, standards development and policy analysis.

Development—Includes such responsibilities as public education, resource development, training and education, research and development and legislative activities.

Administration—Includes such responsibilities as bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring, and quality assurance.

Access/Care Coordination—Includes such responsibilities as outreach, screening, assessment, case management, information and referral.

Service Delivery—Includes those activities associated with the direct provision of a service that meets the needs of an individual older person and/or caregiver.

Clerical/Support Staff—All paid personnel who provide support to the management and professional staff.

Provider – An organization or person which provides services to clients under a formal contractual arrangement with an AAA or SUA. Under Title III-E, in cases where direct cash payment is made to a caregiver and the ultimate provider is unknown, the number of providers may be omitted.

Minority Provider – A provider of services to clients which meets any one of the following criteria: 1) A not for profit organization with a controlling board comprised at least 51% of individuals in the racial and ethnic categories listed below. 2) A private business concern that is at least 51 percent owned by individuals in the racial and ethnic categories listed below. 3) A publicly owned business having at least 51 percent of its stock owned by one or more individuals and having its management and daily business controlled by one or more individuals in the racial and ethnic categories listed below. The applicable racial and ethnic categories include: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or Hispanic.

Rural Provider – Providers of services to clients who live in rural areas. Rural providers are not necessarily providers of services only to rural clients. They may also be providers of services to clients in urban areas. [See definition of rural].

Total OAA Expenditures—Outlays/payments made by the SUA and/or AAA's using OAA federal funds to provide an allowable service.

Total Service Expenditure – OAA expenditures plus all other funds administered by the SUA and/or AAA's on behalf of elderly individuals and caregivers for services meeting the definition of OAA services – both services which are means tested and those which are not. SUAs are encouraged to report expenditures in these service categories whether or not AoA funds were utilized for that purpose. This is not intended for financial accountability but for statistical purposes such as computing accurate service unit costs based on total service expenditures.

Program Income—Gross income received by the grantee and all sub grantees such as voluntary contributions or income earned only as a result of the grant project during the grant period.

Rural—A rural area is: any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.

COMMONWEALTH of VIRGINIA
Department for the Aging
Jay W. DeBoer, J.D., Commissioner

MEMORANDUM

TO: AAA Directors

FROM: Bill Peterson

DATE: November 18, 2003

SUBJECT: **Joint Commission on Health Care's Proposed Legislative Platform**

Attached is an article from Bill Murray regarding the Joint Commission on Health Care's Decision Matrix for their 2004 Legislative Platform. A copy of the Decision Matrix is also attached.

Attachments

1600 Forest Avenue, Suite 102, Richmond, Virginia 23229
Telephone (804) 662-9333 (V/TTY) Fax (804) 662-9354 Toll-Free (800) 552-3402 (V/TTY)

Summary of the November 12, 2003
Joint Commission on Health Care Meeting

The Preliminaries

There were a briefings and then they did the decision matrix. The first briefing was from Dick Grinnan on "What Does VHI Do?" The fact that they are still having to do this sort of briefing after ten years says a lot.

April Kees then presented a staff briefing on how poorly we pay physicians through Medicaid. The policy options all involved spending more and will be covered under decision matrix below.

The Decision Matrix [The Commission's Proposed Legislative Platform for 2004]

The matrix was divided in three parts, JCHC studies, Long-term Care Subcommittee Studies, and Behavioral Health Care Subcommittee Studies.

JCHC Recommendations

Study on Electronic Monitoring of Nursing Home Patients

This study dealt with whether "granny cams" should be allowed in nursing homes; basically the same kind of thing used by parents to monitor their nanny's (nanny cams hidden in teddy bears, that sort of thing). The commission staff decided there was no problem with current law. The commission voted to send a letter to the health commissioner asking him to develop guidelines for electronic monitoring in nursing facilities (this was Option IV on page 7). There is no fiscal impact.

Study of Healthy Lives Prescription Assistance Plan

The commission confronted its contradictory desires to do something in this area and to not spend any money doing it. They chose Options II and III on page 9 of the decision matrix. Both of these options involve further study of the issue.

On page 10 of the decision matrix they selected Option II, which is to introduce a budget amendment for $110,000 GF in each year of the biennium to fund the Rx Partnership, which is a Virginia Health Care Foundation project (this would fund about 1/2 of the program's budget).

Community Based Health Improvement Initiatives

While staff have done some work in this area, the commission decided it needed further study and voted to add it to their 2004 work plan.

Additional Statutory Authority for JCHC

The commission voted to introduce legislation giving itself the same authority as JLARC to request information from executive branch agencies (Option II, page 13). Apparently the commission's interactions with an executive branch agency this year gave rise to this recommendation.

Prevalence of Prostate Cancer

The commission voted to pursue Option II, which involved sending another letter to Commissioner Stroube, this one asking him to consider data, grants, and other issues in this area.

Nurse Practitioner Prescriptive Authority

The commission discussed this issue for awhile. The long and short of their concerns is that they granted the authority so nurse practitioners would provide primary care in rural areas, but that this isn't happening. The commission voted to pursue Option III on page 17, directing the Boards of Nursing and Medicine to conduct an in-depth study of the impact of nurse practitioner prescriptive authority on health access. The commission said no fiscal impact, DHP may disagree.

Medicaid Reimbursement of Physicians

The commission voted to introduce budget amendments to raise Medicaid reimbursement for physicians to 75 percent of the Medicaid schedule (Option IIIA, Page 20). Fiscal Impact is $6.3 million GF annually. They also voted to conduct further study of this issue (Option V, page 20).

<u>Long-term Care Subcommittee Recommendations</u>

The commission took these recommendations in a block. They voted to do the following:

Options IV and V on page 25 related to long-term care insurance. Fiscal impact from Option IV to convert the existing deduction to a credit (tax estimated a revenue impact of as much as $75 million annually). Delegate Hamilton requested that this be implemented in a revenue neutral way, by lowering the amount of the credit to equal the revenue impact of the deduction. Option V has a fiscal impact of $50,000 in each year.

Option II on page 28, to work with the Bureau of Insurance and DMAS on issues related to liability insurance for long-term care providers. It should be noted a

couple of the industry lobbyists in the audience told me this problem is starting to abate a little.

Option III A on page 31, to introduce a budget amendment to increase the personal maintenance allowance for Medicaid Home and Community Based Waivers to 150 percent of Social Security Income (I think they mean SSI here, not Social Security Income which is something different). Anyway, the fiscal impact is $1.53 million.

Option II (amended) and Option III on page 32. Option II, as amended, is to increase the personal care rates by $1 in 05 and $2 in O6. Fiscal Impact is about $5.2 million GF in FY 2005 and $15.6 million GF in FY 2006.

Behavioral Health Care Subcommittee Recommendations

After much discussion, the commission voted to send a letter to DMAS requesting that DMAS hold off on making a decision about including antidepressants in the PDL until July 1, that DMAS consider medical not fiscal issues in doing this, and that DMAS consider allowing psychiatrists open access to antidepressants while putting restrictions on other physicians (this was Delegate Morgan's amendment). There was some talk that the JCHC might meet again briefly during the session to review a revised letter. This was Option 1 on page 35.

On page 37 the commission voted to continue working on a cross training curriculum with DCJS for working with individuals with behavioral health disorders.

On page 41, the commission voted to ask DJJ to send a letter to localities on data reporting, including the AG's opinion that it was ok to report the data described on this page, not withstanding the requirements of HIPAA. This is not listed as an option but is the third paragraph from the bottom of the page. They discussed this for about 10 minutes and I'm still not sure what this involves.

On page 44, the commission voted to pursue Option 1 (not the alternative language) and Option II. Delegate Athey voted "no" because he opposes drug courts. Senator Martin spoke in strong support of drug courts.

That's a summary of today. Enjoy reading the attached decision matrix!

Bill Murray

JOINT COMMISSION ON HEALTH CARE

Decision Matrix for 2004 General Assembly

November 12, 2003

JCHC Decision Matrix

Purpose of Document:

A. To review and consider findings, public comments, and policy options regarding staff reports and other issues that came before JCHC and its Subcommittees in 2003.

B. To develop JCHC recommendations to the 2004 General Assembly.

JCHC Decision Matrix

- **Studies and Issues Considered by JCHC**

- *Recommendations of the Long-Term Care Subcommittee* *(p. 21)*

- *Recommendations of the Behavioral Health Care Subcommittee* *(p. 33)*

Electronic Monitoring in Nursing Facilities

REVIEW OF STUDY FINDINGS

SB 922 (2003) would amend Code of Virginia §§ 32.1-127, 32.1-138, and 32.1-138.1 to require the Board of Health to promulgate regulations that "authorize the use of electronic monitoring devices in the room of a resident of a nursing home…for the purpose of detecting abuse or neglect of elderly or disabled persons…."
SB 922 was passed by in the Senate Committee on Education and Health which also forwarded SB 922 to JCHC for study.

The issue of enhanced protection for the approximately 1.5 million residents of NFs in the U.S. has gained interest in recent years. Electronic monitoring is one initiative that has been considered in at least seven states.

Federal and State Law

Provisions of federal and state laws must be considered with regard to electronic monitoring. Federal law in U.S.C. Title 18 Chapter 119 prohibits the taping, transfer, or disclosure of private wire, oral, or electronic communications (oral communication) unless at least one participant has consented to the interception. Violation of the federal Wiretap Act may result in considerable civil damage awards. State law in *Code of Va*. Title 19.2 Chapter 6 contains similar provisions to the federal Wiretap Act. In addition, *Code of Va*. § 18.2-386.1 prohibits filming, videotaping or photographing "any nonconsenting person if (i) that person is totally nude, clad in undergarments, or in a state of undress so as to expose the genitals, pubic area, buttocks or female breast in a restroom, dressing room, locker room, hotel room, motel room, tanning bed, tanning booth, bedroom or other location and (ii) the circumstances are otherwise such that the person being videotaped or filmed would have a reasonable expectation of privacy."

Representatives of the Va. State Police and VDH indicated that with proper consent and notification protections in place, electronic monitoring could be undertaken without any change in Virginia's law.

Legislation Enacted by Other States

Legislation has been considered in at least seven states, but to date only three states have enacted legislation.

- Texas enacted legislation in 2001 to allow monitoring in residents' rooms
- Maryland enacted legislation in 2003 to require the Md. Dept. of Health and Mental Hygiene to develop guidelines for monitoring undertaken at the NF's discretion with resident consent
- Louisiana, by concurrent resolution in 2003, directed the Dept. of Health and Hospitals and the La. Nursing Home Assoc. "to implement a pilot project [in one NF] to study the practicality of installing electronic monitoring devices in nursing home facilities" and to report prior to the 2004 legislative session.

Provisions Contained in SB 922

SB 922 would amend *Code of Virginia* § 32.1-127 to require regulation to include:

- Delineation of electronic monitoring devices allowed
- Consent form denoting sole right of resident if capable of informed decision, and if not, legal representative must make request
- Form to release NF from "civil liability for violation of the privacy rights of the resident who is the subject of the request as well as any other residents in the same room"
- Form to allow roommates to consent to monitoring, and to be "provided privacy protections…or to be moved to another room"
- Procedure to discontinue monitoring if another resident moves in
- Requirements for signs to denote electronic monitoring
- Timeframes for notice regarding initiation of monitoring
- Requirements for reporting abuse/neglect identified through monitoring
- Requirements for placement of electronic monitoring devices
- Protections for residents who do not favor monitoring
- Penalties for NFs that fail to comply with the requirements

Concerns Expressed about SB 922

VDH did not take a position on SB 922 but expressed concerns

- Primary concern is the protection of the privacy rights of the resident and any roommate with regard to "NOT exposing naked, private parts" with consent and ensuring that family members cannot insist on camera use over the resident's objection
- Second concern is bill may represent "unnecessary governmental interference as there are already laws in place to accommodate the use of cameras."

A number of provider groups had concerns regarding enacting SB 922 – AHCA, VHCA, VHHA, and VANHA.

Support for SB 922

Law enforcement personnel generally supported SB 922 provisions:

- OAG Medicaid Fraud Unit Director indicated monitoring could assist in ensuring that care paid for by Medicaid is being provided, but noted HIPAA provisions should be considered in implementation.
- Sheriff's Dept. Representative indicated that monitoring would be useful in identifying and substantiating abuse and neglect but the Sheriff's Dept. would not have the staff or resources to be responsible for the cameras.
- VSP Representative indicated that monitoring would be useful as an "objective witness" which would be particularly useful in cases in which the victim would not be able to testify. However, it would be important to

post notices to address the expectation of privacy, otherwise one consenting individual would need to be present at all times.

Moreover, a number of patient advocacy groups including AARP, the Helen Keller Center for Deaf-Blind Youths and Adults, and TLC 4 Long Term care support the SB 922 provisions.

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

Three comments were received **in support of Option I**.

Virginia Department of Health, Virginia Health Care Association, and Virginia Hospital & Healthcare Association.

Option II: Introduce legislation to amend the *Code of Virginia*, Title 32.1 to incorporate the provisions of Senate Bill 922 (2003) requiring the Board of Health to promulgate regulations authorizing electronic monitoring in nursing facilities.

24 comments were received **in support of Option II**.

Barbara Chewning, Jay Chidlaw, Janet L. Clement, Mary M. Davis, Friends and Relatives of Nursing Home Residents, Rosemary Furcher, Mary Highsmith, Sandra Martin, Bernadette McConnell, Anne M. McGraw, Mary A. Mulherin, Northern Virginia Long Term Care Ombudsman Program, Carol Nottingham, Carol O'Connor, Susan and Lewis Pauley, Perrie Powers, Evelyn D. Proctor, Jake and Victoria Saker, Sheila and Bernard Smith, State Long-Term Care Ombudsman, Daniel, Danielle and Sandra J. Taylor, Virginia Coalition on Aging, and Dottie Lee Wingo, Nurse Practitioner *(No Name Provided)*.

Option III: Introduce legislation to amend the *Code of Virginia*, Title 32.1 to incorporate the provisions of Senate Bill 922 (2003) as well as to require the Board of Health to include one or more of the following provisions in the regulations the Board promulgates:

A. Notify residents of their liability for violating privacy laws due to noncompliance with regulation or covert monitoring.

B. Require that covert monitoring (except for covert monitoring undertaken by law enforcement authorities) when discovered must be discontinued with the stipulation that authorized monitoring may be initiated after all requirements for monitoring have been met.

C. Specify that all installation, operating, maintenance, and repair costs related to the monitoring, except the cost of electricity, will be the responsibility of the resident or the resident's family or legal representative.

D. Specify that the resident, not the nursing facility is responsible for retrieving and replacing any tapes used in monitoring.

E. Specify that the resident, not the nursing facility is responsible for ensuring that the roommate's conditions for consenting to monitoring are

observed.

F. Specify that the resident, not the nursing facility is responsible for ensuring that electronic monitoring is discontinued if a new roommate moves into the room and that the monitoring will not resume until all requirements for consenting to the monitoring have been completed with the new roommate.

G. Provide guidance regarding steps the nursing facility should take to ensure compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.

Option IV: Send a letter from the Chairman of the Joint Commission on Health Care to the State Health Commissioner to request that the Department of Health monitor the issue of electronic monitoring to determine the necessity for initiating pilot projects and/or for developing advisory guidelines for electronic monitoring in nursing facilities.

One comment was received addressing Option IV.

Virginia Health Care Association indicated **having no objection to Option IV.**

In response to a request by JCHC, **the State Health Commissioner responded regarding VDH's ability to implement Option IV**. The Commissioner indicated that VDH is in the process of amending its current guideline on electronic monitoring to be more detailed. In addition, VDH "would also consider initiating a pilot project, based on the guideline, should the need become evident. However, based on the experience in Maryland in developing its pilot project, we are uncertain as to the viability or benefit of such a project. However, if it becomes apparent that a pilot project would be helpful, the Center [for Quality Health Care Services and Consumer Protection within VDH] would first attempt to solicit volunteers to carry the cost of the project, which would result in no additional impact to the Center. Should a volunteer effort fail, however, the Center could not mandate participation and a pilot project would not be possible. As we stated in an earlier letter, though electronic monitoring technology is fairly new, we expect its use to become commonplace in the future. We also believe that the guideline will appropriately address the concerns of nursing facilities while providing a foundation for family members. **Therefore we support Option IV as an appropriate alternative** to address the concerns of individuals responding to the study."

Healthy Lives Prescription Assistance Plan

REVIEW OF STUDY FINDINGS

HB 2225 and SB 1341 (2003) established the Healthy Lives Prescription Assistance Fund, under the auspices of the Sec. of Health and Human Resources to "accept appropriations, donations, grants, and in-kind contributions to develop and implement programs that will enhance current prescription programs for citizens of the Commonwealth who are without insurance or the ability to pay for prescription drugs and to develop innovative programs to make such prescription drugs more available." HB 2225 and SB 1341 include a second enactment clause that requires JCHC to prepare a Plan "to provide prescription drug benefits for low-income senior citizens and persons with disabilities…."

Need for Prescription Coverage

The majority of seniors have insurance coverage for medical benefits (typically through Medicare) but prescription drug coverage is often lacking.

- Seniors often lack comprehensive prescription drug coverage at a time when they need it most to address chronic diseases.
- A number of studies have reported on the relationship between prescription drug coverage and compliance with taking prescriptions in the dosage and frequency prescribed.

The Joint Commission Studying Prescription Drug Assistance reported in its final report, HD 32 (2003) that of the 930,000 Medicare eligible individuals living in Virginia in 2001, 400,000 had no prescription coverage – 162,000 of whom have incomes below 200% of FPG ($17,960 for 1; $24,240 for 2).

Development of Healthy Lives Prescription Assistance Plan

To develop recommendations for the Plan, a diverse group of interested parties representing advocacy groups, health care providers and associations, pharmaceutical manufacturers, state agencies, and the Secretary of Health and Human Resources participated in workgroup meetings. Delegate Cline and Senator Potts' aide were involved in designing the Plan.

The focus of the Plan is to establish a public-private partnership to develop a statewide system for assisting seniors, who do not have prescription drug coverage, in obtaining their prescription drugs. The recommendation is to have a two-phase implementation.

Phase I would include such activities as informing seniors and their families regarding the existence of discount cards for pharmaceuticals:

- Include a description of the discount cards and list the toll-free telephone numbers for use in newsletters, newspapers, and other publications.
- Issue public service announcements and press releases about the cards.

Phase I would also include affiliating with existing opportunities in the community to provide one-on-one assistance in filling out applications.

Phase II would include such activities as:

- Monitoring the actions of Congress on a prescription drug benefit for Medicare
- Examining what other states are doing to assist seniors
- Encouraging Virginia-based initiatives such as The Pharmacy Connection
- Continuing to develop partnerships with community-based entities such as pharmacies, faith-based organizations, human service agencies, and advocacy associations.
- Considering legislation to increase the income limits for Medicaid eligibility in Virginia.

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

Option II: Submit recommended two-phase Plan to chairmen of House Appropriations, Senate Finance Committee, House Committee on HWI, and Senate Committee on Education and Health.

Option III: Continue to address development of the Healthy Lives Prescription Assistance Plan by including the issue on the JCHC workplan for 2004.
One comment was received in **support of Option III**.
Virginia Association of Area Agencies on Aging

Excerpt of Comment by Virginia Association of Area Agencies on Aging
"In the Healthy Lives Prescription Assistance Plan outlined, we are supportive of the Phase I and Phase II activities contained in the report. We ask, however, that the Commission act upon all of Phase I and Phase II in the upcoming 2004 General Assembly Session, including legislation to increase the income limits for Medicaid eligibility for Seniors. Second, we ask that the Commission proposes by resolution to continue to refine the Healthy Lives Prescription Assistance Plan to include more aggressive activities that result in more comprehensive solutions for the greatest number of Virginia's Seniors in need. For example, after a closer examination of the successes achieved in other states, a specific program should be developed and recommended to allow the greatest number of needful Seniors to benefit. Attempts to address this issue with low or no-cost programs will not provide the Assembly with the assurance that the all Virginians have access to needed medications as they age."

Rx Partnership

REVIEW OF PRESENTATION FINDINGS

The Rx Roundtable was established and included a diverse group of participants representing Carilion Foundation, MSV, Northern Neck Free Health Clinic, REACH, Sentara Health Foundation, VA Assoc. of Free Clinics, VA Board of Pharmacy, VCU, VHCF, VHHA, VA Pharmacists Assoc., VA Primary Care Assoc., and Liz Nilsen (former director of MedsHelp). The purpose of the Rx Roundtable was to "design a statewide strategy that increases access to free prescription medicines for eligible individuals without insurance."

Model Selected for Rx Partnership (RxP)

To operate a "virtual warehouse" of free prescription medications for Virginians who lack prescription coverage. RxP will serve as the broker to:

- Solicit contributions from donors and free prescription medications from pharmaceutical manufacturers who agree to participate
- Arrange for distribution of donated prescriptions directly from pharmaceutical manufacturers to network affiliates (initially health safety net providers including free clinics, VDH clinics, FQHCs) and
- Credential the network affiliates who participate in the program.

The expected Benefits of RxP include:

- Increase the number of eligible, "prescription-uninsured" Virginians who receive prescribed medication
- Assist health safety providers in addressing patient needs
- Reduce the number of requests and administrative burden on pharmaceutical manufacturers who choose to provide free prescription medication while providing controls through credentialing, monitoring, and evaluation
- Provide a partial solution to providing needed prescription medication to individuals lacking coverage and the ability to pay
- Provide attention to the contributions of Partnership associates.

Organizational Structure and Current Status of RxP

RxP is a 501(c) 3 nonprofit organization seeking to be a private-public partnership that is governed by a Board of Directors. RxP has incorporated and raised $52,500 of the $75,000 budget for the first 9 months of operation, one staff member has been employed, and the credentialing committee has drafted criteria for participation.

OPTIONS

Option I: Take no action.

Option II: Introduce a budget amendment for $110,000 in GFs for each year of the 2004-06 biennium.

Community-Based Health Improvement Initiatives

REVIEW OF PRESENTATION FINDINGS

HJR 51 in 2002 requested that JCHC, in consultation with key stakeholder groups develop a plan to implement community-based health improvement initiatives. The development of community-based health improvement initiatives is supported by the Virginia Center for Healthy Communities, a public-private partnership whose goal is to enhance community health through greater involvement by the business community.

Since 1996, Virginia has slipped in national rankings of overall health status from 10th to 19th. Preventable diseases and conditions represent critical opportunities for public and private entities at the local level to work to reverse this trend. During the summer of 2002, a workgroup met to discuss ways to encourage communities to undertake health improvement initiatives. During the summer of 2003, key informant interviews helped to refine the workgroup's proposals. Key informants, which included local officials, educators, service providers, business leaders, pastors, and foundation executives, observed the following:

- "Tie the outcomes to the incentives; don't reward businesses for just writing a check. Reward them for involving the majority of their employees in a health improvement initiative."
- "The faith community has tremendous potential for impact because they are always looking for an outreach. The state should provide information to the faith community regarding what organizations are out there and what needs exist in their communities."
- "The number one payback for businesses is a productive, well-trained, healthy workforce."

Pilot Project Proposal

A pilot project based on the "Virginia Enterprise Zone model…[to] allow localities to designate a portion of the community to receive incentives and technical assistance…[with] private sector partners and a specific community health improvement project in their applications."

OPTIONS

Option I: Take no action.

Option II: Introduce a budget amendment for $50,000 in GFs for each year of the 2004-06 biennium to fund a pilot project implementing a community-based health improvement initiative. The amendment would require matching funds to be provided from within the community or local government.

Option III: Continue to address development of community-based health improvement initiatives by including the issue on the JCHC workplan for 2004.

Additional Statutory Language for JCHC

JCHC members may want to consider amending the current statutory language for the Joint Commission on Health Care (*Code of Virginia* Title 30, Chapter 18) to add language that more explicitly states the responsibility of state entities to provide information and assistance to JCHC.

CURRENT STATUTORY LANGUAGE FOR JCHC

Code of Virginia § 168.3 provides JCHC with the authority to "study and gather information and data." Section 168.4 of the *Code*, in delineating the authority to employ staff includes the statement: "All agencies of the Commonwealth shall provide assistance to the Commission, upon request."

STATUTORY LANGUAGE FOR OTHER LEGISLATIVE COMMISSIONS

Commission on Youth

The statutory language addressing the authority of the Commission on Youth is more definitive in stating:

§ 30-177. Cooperation of other state agencies.
The Commission may request and shall receive from every department, division, board, bureau, commission, authority or other agency created by the Commonwealth, or to which the Commonwealth is party, or from any political subdivision of the Commonwealth, cooperation and assistance in the performance of its duties.

State Crime Commission

The statutory language for the Crime Commission is almost exactly the same as the language addressing the Commission on Youth.

§ 30-159. Cooperation of state agencies; consultation with other states.
A. The Commission may request and shall receive from every department, division, board, bureau, commission, authority or other agency created by the Commonwealth, or to which the Commonwealth is a party or any political subdivision thereof, cooperation and assistance in the performance of its duties.

Joint Legislative Audit and Review Commission (JLARC)

Statutory language addressing JLARC's authority delineates that all State agencies are expected to provide information and defines state agency as "all executive, judicial, and legislative agencies of the Commonwealth as well as all constitutionally or statutorily created state entities."

§ 30-59. State agencies to furnish information and assistance.
All agencies of the Commonwealth, their staff and employees shall provide the Commission with necessary information for the performance of its duties, and to afford the Commission's staff ample opportunity to observe agency operations.

§ 30-59.1. State agency defined.
For the purposes of §§ 30-58.1 and 30-59, the terms "state agency," "state agencies," "agency," and "agencies" shall mean all executive, judicial, and legislative entities of the Commonwealth as well as all constitutionally or statutorily created state entities.

OPTIONS

Option I: Take no action.

Option II: Introduce legislation to amend *Code of Virginia* Title 30, Chapter 18 to include language that explains the responsibility of state entities upon request to provide information and assistance to the Joint Commission on Health Care.

Prevalence of Prostate Cancer in Virginia

REVIEW OF PRESENTATION FINDINGS

A representative of the Virginia Prostate Cancer Coalition presented information on prostate cancer from the American Cancer Society using information from 1995-1999 that indicated:

- Virginia ranked 32nd in incidence of prostate cancer (145.4 per 100,000 in VA versus 168.9 in US)
- Virginia ranked 8th in terms of mortality (39.1 per 100,000 in VA versus 33.9 in US)

More recent Virginia-specific information was also reported that indicated for 2000, the mortality rate for prostate cancer in Virginia was 21.6 per 100,000. But there were localities that had significantly higher mortality rates, with the top five localities being:

- Emporia – 155.3 per 100,000
- Lancaster – 130.3
- Clifton Forge – 105.7
- King and Queen – 92.8
- Amelia – 88.9

The Virginia Prostate Cancer Coalition recommends that VDH request funds from the Centers for Disease Control "to facilitate additional prostate cancer data collection for the Virginia Cancer Registry and for expanded questions in the annual Behavioral Risk Factors Surveillance Survey" in order to "help determine progress in reducing the late-stage diagnosis of cancers. Funds are also needed for early detection programs."

OPTIONS

Option I: Take no action.

Option II: Send a letter from the Chairman of the Joint Commission on Health Care to the State Health Commissioner to request that the Department of Health consider the issues brought forward by the Virginia Coalition on Prostate Cancer with regard to enhancing data collection and seeking grant funding for cancer prevention and early detection initiatives.

Nurse Practitioner Prescriptive Authority

REVIEW OF STUDY FINDINGS

House Bill 818 (HB 818) of the 2000 General Assembly Session expanded the prescriptive authority of nurse practitioners. Specifically, the prescriptive authority for nurse practitioners changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) for the authority to prescribe Schedules III-VI drugs. An enactment clause in HB 818 required the Joint Commission on Health Care to provide a report on the issue of prescriptive authority for nurse practitioners prior to the 2004 General Assembly Session. Specifically, the Commission is required by the enactment clause:

> …to study nurse practitioner prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules III through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.

Growth in the Number of NPs

The number of nurse practitioners (NPs) in Virginia has more than doubled between 1994 and 2003. At the time of the study, the **number of licensed NPs was 4,621**. The **number of NPs with prescriptive authority was 2,347**. Because one category of NPs, nurse anesthetists, is not eligible for prescriptive authority, the number of **eligible** NPs with prescriptive authority is approximately 74 %.

Virginia Data on NPs

The Board of Nursing (BON), which collects information about NPs, does not collect information regarding the practice locations of NPs and the changes to the written practice agreements between physicians and NPs. This information would have been beneficial for the purposes of this study. Available data about disciplinary actions against NPs and NPs with prescriptive authority showed a low occurrence of complaints and sanctions that indirectly suggests that NPs are providing quality care and that patient satisfaction is likely to be relatively high.

Information on Other States

All states allow some type of **prescriptive authority** for NPs. The majority of states (33), including Virginia, allow NPs to prescribe drugs including controlled substances with some type of physician involvement. Five states allow NPs to prescribe drugs excluding controlled substances with physician involvement. And, 12 states allow NPs to independently prescribe drugs including controlled substances. In reviewing this information, it was clear that Virginia fell into a middle category as to the level of independence in NP prescriptive authority.

Virginia is in a more restrictive category in regards to **NP scope of practice.** Virginia requires physician supervision for prescriptive authority and is one of only 5 states that have scope of practice authorized by both a board of nursing and a board of medicine. Views on scope of practice issues vary greatly between

NP and physician organizations and/or associations.

The 5 states that border Virginia provide nurse practitioners with **mandated direct third-party reimbursement status and primary care provider status**.

Mandated Areas of Study

With regard to areas mandated for study, JCHC staff found:

- A number of studies conducted in the United States have shown that **quality care is being provided by NPs**. Moreover, it is likely that the increase in NP prescriptive authority in Virginia has had a positive impact on patient care.
- The research on **provider relationships is ambiguous**; making further extrapolation to the impact increased NP prescriptive authority has had on provider relationships difficult.
- **Increases in NP prescriptive authority have lead to more direct reimbursement for NPs in other states**. Current **Virginia laws and regulations limit the ability of NPs to be reimbursed directly** by some categories of payers.
- The impact that the increase in NP prescriptive authority has had on **physician practices** is closely tied with other previous categories (for instance, physician practices are impacted by provider relationships). **Physicians in practice were impacted in their day-to-day operations if they employed NPs when the NP prescriptive authority increased**. **Some individuals contacted** as part of the study indicated that the **increased NP prescriptive authority was beneficial** to physicians and NPs in that it **reduced some burdens**. Some of these decreases in burdens likely increased the efficiency of some physician practices.
- A number of studies indicated that **patient satisfaction exists with NP services generally**. In addition, anecdotal evidence suggested that patient satisfaction with regard to NP prescriptive authority was high.

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

One comment was received **in support of Option I**.
Virginia Council of Nurse Practitioners.

Option II: Require the Board of Nursing to collect additional data pertaining to nurse practitioners and prescriptive authority of nurse practitioners. This data should be reported to the Joint Commission on an annual basis beginning in 2005.

Option III: Introduce a joint resolution directing the Board of Nursing and the Board of Medicine or other designated agencies to conduct an in-depth study on the impact that increased nurse practitioner prescriptive authority to prescribe Schedules III through VI controlled substances and devices has had on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with nurse practitioner treatment.

One comment was received **in opposition to Option III**.
Virginia Council of Nurse Practitioners.

Option IV: Introduce legislation to recommend that nurse practitioners be granted mandated provider status as related to accident and sickness insurance companies.

One comment was received **in opposition to Option IV**.
Virginia Association of Health Plans.

One comment was received **stating that Option IV should be on hold for some time**.
Virginia Council of Nurse Practitioners.

Medicaid Reimbursement of Physicians

REVIEW OF STUDY FINDINGS

HJR 42 and SJR 38 requested that JLARC study Medicaid reimbursement of physicians. Both resolutions were carried over in their respective Committees on Rules. JCHC added the study to the workplan in 2002 and continued to review the issue in 2003.

In Virginia, the Medicaid system has both a fee-for-service payment system as well as a managed care program. The study completed in 2002 focused on the fee-for-service component of Medicaid physician reimbursement and updates to this information were provided during 2003.

Medicaid Reimbursement of Physicians in Virginia

Virginia Medicaid physician reimbursement is based on a resource-based relative value scale (RBRVS) system. An RBRVS system is one based on the use of relative value units (RVUs). RVUs are essentially measures of resource utilization and are assigned to services billed under national coding systems. Virginia's methodology for reimbursing physician services was developed based on Medicare's methodology which uses an RBRVS system.

Under the Medicare RBRVS system the amount paid for services is the product of:

- a nationally uniform relative value for each service,
- a geographic adjustment factor (GAF) for each area,
- and a nationally uniform conversion factor.

There are RVUs assigned for physician work, practice expense, and malpractice expense. RVUs are adjusted for geographic differences in cost with geographic practice cost indexes (GPCIs). The conversion factor (CF) is the adjustment that allows for the calculation of the payment for service. The methodology is represented by the following:

CF X [(RVUW X GPCIW) + (RVUP X GPCIP) + (RVUM X GPCIM)]

Virginia's current system for physician reimbursement is essentially based on the Medicare methodology with the addition of a budget neutrality factor and the deletion of the use of geographic adjustment factors (GAF). The methodology is represented by the following:

(CF) x (RVUtotal) x (Budget Neutrality Factor)

The budget neutrality factor is approximately the percentage of Medicare that Virginia can afford to pay based on the funding that is available (currently this is 69.67% of Medicare). This methodology is used for all specialties except OB/GYN.

1998 Research Conducted by the Urban Institute

According to a study conducted by the Urban Institute in 1998, Medicaid

physician fees paid by the states declined between 1993 and 1998. Physician fees in Virginia declined for all services by 22.2 percent. Decreases were also observed for obstetric care fees and other service fees but primary care fees increased. States also experienced a decline in their Medicaid reimbursement of physician services as compared to Medicare. Virginia's ratio decreased by 15.3 percent.

Other State Surveys

JCHC staff conducted surveys of other states to in 2002 and 2003 to determine whether the states used an RBRVS system for Medicaid physician reimbursement and what their current Medicaid payments are as a percentage of Medicare. The states surveyed included AL, FL, GA, KY, LA, MD, MS, NC, SC, TN, and WV. The majority of surveyed states (including Virginia) use some form of an RBRVS methodology for calculating Medicaid physician reimbursement. When comparing 2002 and 2003 Medicaid rates for physician reimbursement to those reported by the Urban Institute study in 1998, you find that: three states plus Virginia experienced a decrease in Medicaid rates, four states experienced an increase in Medicaid rates, and three states did not have data available for one or both years in regards to Medicaid rates.

Concerns of Provider Groups

In 2002, JCHC staff discussed Medicaid physician reimbursement with provider groups and their representatives. These groups expressed concerns about reimbursement that included: rates were too low, low rates would eventually lead to access issues for specialists, providers who see a large percentage of Medicaid patients are at a disadvantage, and specialties in general do not fare well under an RBRVS system in comparison to preventive services. JCHC staff developed several policy options to address some of these concerns in 2002. However, the options that raised reimbursement rates would have substantial costs. JCHC voted to keep this issue on the workplan for 2003.

In 2003, JCHC staff conducted a physician focus group on the topic and the group reiterated the concerns that had been expressed previously. However, comments from the group lead to the suggested inclusion of some additional options for future research and consideration.

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

Option II: Introduce a budget amendment (language and funding) to recommend that Medicaid physician reimbursement be paid at approximately the same rate as Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2004 would be $50.9 million.

One comment was received **in support of Option II** in 2002 but was not requesting action until Virginia's budget deficit was addressed.

Virginia Chapter of the American Academy of Pediatrics (VA-AAP).

One comment was received in 2002 that **would support** an increase in physician reimbursement but **is not requesting action** until the economic outlook improves.

Medical Society of Virginia (MSV).

Option III: Introduce a budget amendment (language and funding) to recommend that:

A. Medicaid physician reimbursement be paid at 75 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2004 would be $6.3 million.
B. Medicaid physician reimbursement be paid at 80 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2004 would be $15.2 million.
C. Medicaid physician reimbursement be paid at 85 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $24.2 million.

Option IV: Introduce budget amendment (language and funding) to recommend that Medicaid physician reimbursement be altered to provide a five percent increased rate of reimbursement to physicians who practice in a locality that has:

A. Greater than 10 percent of their total population eligible for Medicaid; the estimated general fund amount for FY 2004 would be $3.2 million.
B. Greater than 15 percent of their total population eligible for Medicaid; the estimated general fund amount for FY 2004 would be $1.1 million.

Option V: Include in the **2004** workplan for the Joint Commission on Health Care, further study and analysis of issues related to Medicaid physician reimbursement. This further analysis would include examination of an inflation factor methodology and a disproportionate share concept.

JCHC Decision Matrix

- ❑ *Studies and Issues Considered by JCHC*
- ❑ **Recommendations of the Long-Term Care Subcommittee**
- ❑ *Recommendations of the Behavioral Health Care Subcommittee* *(p. 33)*

Long-Term Care Insurance Incentives

REVIEW OF STUDY FINDINGS

Long-term care insurance (LTCi) was introduced in the 1980s and differs from medical insurance in that it is designed to help a person maintain his/her level of functioning rather than trying to correct medical problems. LTCi covers services that help with activities of daily living (ADLs) and/or cognitive impairment.

Comprehensive LTCi covers services that help with ADLs, home health care, and respite care. It also can provide coverage in all settings, such as nursing homes, home health, assisted living, and adult day care.

LTCi Policies

After meeting a deductible, most policies pay a fixed dollar amount per day. Within policies, there are two methods of qualifying for benefits, cognitive and/or physical impairment.

Premiums are based on the age/health status of the policyholder and the benefits of the policy. According to the American Council of Life Insurers, the cost of premiums is less than what a person would pay for long-term care services. Costs for one year in a nursing home currently average $45,000.

Purchase of LTCi

By the end of 2001, 8.26 million LTCi policies had been sold. This is still a relatively small number of policies:

- 80% of policies are individual/association policies and
- few employers contribute to the cost of coverage (this number is increasing and doubled between 1998 and 2001).

Methods to Increase Purchase of LTCi

LTCi experts indicate that several U.S. Tax Code changes would increase the purchase of LTCi:

- "de-coupling" the tax deduction for LTCi coverage from the uncompensated medical expense deduction (>7.5% of AGI) to an "above the line" deduction and
- allowing employers to include LTCi benefits in "cafeteria" or Section 125 flexible benefit plans (S. 100 addresses this issue).

Research suggests that other strategies would increase the purchase of LTCi policies. These strategies include:

- providing tax incentives that reduce the net cost of LTCi policies,
- encouraging employer-based private LTCi through tax incentives and through federal and state governments serving as role models by providing their employees with the opportunity to purchase LTCi, and
- waiving some or all of the Medicaid asset depletion requirements, allowing individuals with LTCi to retain more of their assets and still be

eligible for Medicaid (partnerships).

Another strategy suggested by LTCi experts is to initiate proactive public education/awareness programs on LTCi.

State Tax Incentives for Purchase of LTCi

Twenty-three states provide some type of tax incentives for the purchase of LTCi. Of these 23 states:

- 17 states have tax deductions and
- 6 states have tax credits.

Virginia Tax Incentives

HB 1546 of the 1999 General Assembly Session created an individual income tax deduction for LTCi premiums (effective date of the tax deduction was January 1, 2000). Premiums deducted on federal income taxes cannot be deducted on state income taxes.

LTCi for Federal Government Employees

In December 2001, the federal government contracted with John Hancock and MetLife to provide LTCi. Approximately 20 million people are eligible to apply for this insurance, including employees (most Federal and U.S. Postal Service employees and active members of the uniformed services); annuitants (including retired members of the uniformed services); spouses and adult children of employees and annuitants; and parents, parents-in-law, and stepparents of employees.

LTCi under the federal program requires individuals to apply for coverage and pass a medical screening in order to be enrolled. Some medical conditions will prevent some individuals from being approved for coverage.

LTCi for Virginia State Employees

LTCi is offered to employees (and employees' spouses, parents, and parents-in-law) of state agencies and of THE LOCAL CHOICE partners as well as to state retirees and their spouses. (THE LOCAL CHOICE program provides benefit plans to local governments and officials, teachers, and certain other public authorities.) Daily benefit options range from $50 - $200 and lifetime benefit maximums can be for either a two-year period or a five-year period. This LTCi plan does not include a state contribution to the premium. Enrollment in this plan is relatively low.

In addition, VRS has developed a LTCi plan for state employees enrolled in the Virginia Sickness and Disability Program (VSDP). Unlike the previously described LTCi program, the VRS plan is paid for by the Commonwealth with no employee contribution. The VRS plan's benefits are basic and do not include features in the voluntary program. The plan covers active employees. However, an individual can choose to pay the previous employer-paid contribution to maintain this policy after leaving state employment. The employer-paid benefit

is $75 per day.

LTC Partnerships in Other States

Partnerships for Long-Term Care was a Robert Wood Johnson Initiative created in 1988. Partnerships provided:

- an alternative to spending down or transferring assets by forming a partnership between Medicaid and private insurers,
- allowed participating insurers to offer products that provided better protection against impoverishment, and
- stipulated that once benefits were exhausted, special Medicaid eligibility criteria would apply (limits/eliminates impoverishment requirement).

However, changes occurred under OBRA '93 which stipulated that asset protection is in effect only when the insured is alive. This means that states must recover costs from the estate. This legislation then reduced the value of Partnership policies. The four original states (California, Connecticut, Indiana, and New York) are exempt from OBRA '93; four other states have limited programs; and several others are awaiting repeal of OBRA '93 provisions. As of December 2000, the 4 original states had 78,142 policies in force, 810 policyholders who had qualified for benefits, and 21 policyholders who had exhausted benefits and accessed Medicaid.

Federal legislation introduced this year (H. R. 1406 of the 108th Congress), if passed, would permit additional States to enter into long-term care partnerships.

Additional Federal Legislation

Additional federal legislation, introduced after the May 6th Subcommittee meeting, includes H.R. 2096, which includes U.S. Congressman Eric Cantor as a cosponsor. Provisions in the bill include a federal tax deduction for LTCi, offering LTC benefits to employers through federal pools, and a tax credit of up to $3,000 for those providing in-home care to a relative. Another recently introduced bill, S. 1335 would allow "individuals a deduction for qualified long-term care insurance premiums, use of such insurance under cafeteria plans and flexible spending arrangements, and a credit for individuals with long-term care needs." Both bills have been referred to a committee in their respective houses.

Research on Potential Medicaid Savings

According to a study commissioned by the Health Insurance Association of America (HIAA) on a 100% above-the-line federal tax deduction for LTCi premiums, it was concluded that the deduction "would significantly increase LTC insurance coverage and that the resulting savings in Medicaid spending would more than pay for the foregone tax revenue."

The study was released in March 2000. At that time, the researchers projected that the annual cost of the tax deduction to be between $3.1 billion and $3.5

billion for the five-year period after enactment. The estimated annual Medicaid savings were estimated to be between $3.5 billion and $3.8 billion. However, because "tax expenditures are counted from the year of purchase of the LTC policy, Medicaid savings for each policyholder are realized on average 12 years after the purchase." To make a comparison in "real" dollars the researchers estimate that $1.06 would be saved for every federal dollar spent.

Additionally, the study indicated that they believed states would realize savings from the federal tax deduction as well. The table below provides the summary of these estimations for the 10 states with the largest senior populations.

Estimated Medicaid Savings by State for an Above-the-Line Federal Tax Deduction for LTC Insurance

State	New LTC Policies Purchased (2000-2005)	State Share of Medicaid Savings per Policyholder	Lapse-Adjusted Real Medicaid Savings per Policyholder (State Share)
California	43,000-47,000	$3,651	$1,935
Florida	59,000-65,000	$2,067	$1,096
Illinois	40,000-43,000	$2,819	$1,494
Michigan	21,000-23,600	$2,238	$1,186
New Jersey	11,000-12,200	$4,954	$2,626
New York	16,000-17,000	$4,447	$2,357
North Carolina	10,600-11,500	$1,796	$952
Ohio	29,600-32,200	$2,707	$1,435
Pennsylvania	41,000-45,000	$3,126	$1,657
Texas	31,000-33,500	$2,006	$1,063

Source: *Tax Deductibility of Long-Term Care Insurance Premiums: Implications for Market Growth and Public LTC Expenditures*, HIAA, March 2000 and *LifePlans, Inc.*

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

Option II: Recommend that JCHC introduce legislation (and an accompanying budget amendment) to provide a tax credit for employers who offer LTCi to their employees. Cost estimates have been requested from the Virginia Department of Taxation.

Option III: Recommend that JCHC introduce legislation and a budget amendment (language and funding) to provide a one-time tax credit for individuals purchasing LTCi. (This credit would be in addition to the current annual deduction.) Cost estimates have been requested from the Virginia Department of Taxation.

Option IV: Recommend that JCHC introduce legislation (and an accompanying budget amendment) to provide a tax credit rather than a tax deduction for long-term care insurance. Cost estimates have been requested

from the Virginia Department of Taxation.

Option V: Recommend that JCHC introduce a budget amendment (language and funding) to establish a LTCi public education/awareness campaign. Estimated cost: $50,000 in GFs for each year of the biennium.

Option VI: Recommend that JCHC send a letter to the Virginia delegation in Congress to indicate JCHC's support of S. 100 and H.R. 1406.

Note: Based on the LTC Subcommittee vote at the May 6, 2003 meeting, letters of support of were sent to Virginia's Congressional delegation. The letters that the Commission received in response are included in the last unmarked tab of your notebook.

Option VII: Direct JCHC staff to work with DMAS and others to determine the feasibility of implementing a "Partnership for LTC Program" similar to programs that other states have implemented, if additional states are allowed to enter into the partnerships.

Note: The LTC Subcommittee voted to direct staff to continue to work on this option at the May 6, 2003 meeting.

Long-Term Care Liability Insurance

REVIEW OF STUDY FINDINGS

Long-term care (LTC) liability insurance includes both professional liability (injuries to residents) and general liability (injuries to non-residents). The premiums for this type of insurance are based primarily on: past losses, type of facility, the type of resident incidents, financial strength, and regulatory indicators.

LTC Liability Insurance Crisis

There is currently a long-term care liability insurance crisis. Some believe that the industry is setting premiums based on their experience with facilities in Florida and Texas. Several factors helped precipitate the crisis including: decreased Medicaid reimbursement rates, development of law firms specializing in lawsuits against nursing homes, and enactment of legislation protecting residents against abuse and guaranteeing a minimum standard of care.

National Trends in LTC Liability Insurance

Between 1990 and 1995, costs per bed for LTC liability insurance more than doubled from $240 to $590. By 2001, the average annual rate for this insurance had grown to $2,360 per bed, often with reduced coverage. From 1995 to 2000 LTC liability insurance costs absorbed 20 percent of the increases in Medicaid reimbursement.

State Trends in LTC Liability Insurance

The states that have had the highest losses for insurers are Florida and Texas. In these states, LTC liability insurance has essentially become unavailable at any cost.

- Costs rose to $11,000 per bed in Florida.
- Costs rose to $5,500 per bed in Texas.
- In Alabama, Arkansas, California, Georgia, Mississippi, and West Virginia costs for liability insurance are up to $3,300 per bed.

Most states have not had the same increases as Florida and Texas, but the rates for liability insurance have increased.

Virginia Trends in LTC Liability Insurance

Between 1998 and 2001, the average per-bed premium for LTC facilities in Virginia increased from $25 to $150 for non-profit facilities and from $75 to $500 for for-profit facilities. Since 2001, it has been anecdotally reported that premiums have risen to as much as $1,000 per bed in Virginia.

The number of LTC insurance providers has not changed since 2001. There are four not-for-profit insurers and three for-profit insurers.

HB 2741 (2003) allows for a lien to be placed on a personal injury claim if DMAS

has paid for any health care services.

Future Concerns

Potential future concerns include: loss of current insurers, forced self-insurance, bankruptcy of facilities, and/or unaffordable resident fees.

Possible Solutions

Federal legislation, the Health Act of 2003 (HR5), contained provisions that included:

- limiting the time period for filing health care lawsuits to three years,
- allocating damages in proportion to a party's fault,
- allowing recovery of economic damages,
- limiting the portion of amount that go to attorneys,
- permitting payment of medical expenses to be made periodically, and
- allowing states to retain their damage caps if different from the bill.

The House version of the bill passed on March 13, 2003. The Senate version of the bill was defeated.

The American Health Care Association (AHCA) and the National Center on Assisted Living (NCAL) have a proposal to address LTC liability insurance reform. They support the following in their proposal:

- *Straightforward, fair, and comprehensive limits on medical liability awards that fully cover "alternative" state laws exploited by some to bring standard medical negligence cases against long term care providers.*
- *Limit plaintiff's attorneys' contingency fees in health care actions.*
- *In tandem with these protections, we recognize that common-sense insurance reforms and risk management efforts will play an important role in guaranteeing that liability insurance is available and affordable,*
- *Limit use of data developed for quality improvement purposes in civil litigation.*

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

Option II: Direct JCHC staff to work with the Bureau of Insurance and the Department of Medical Assistance Services to address issues related to professional liability insurance including: monitoring the number of liability insurance providers offering coverage to LTC facilities in Virginia and determining the extent to which the increases in liability insurance are reflected in the rates paid to nursing facilities.

Personal Maintenance Allowance of the Medicaid E&D Waiver

REVIEW OF STUDY FINDINGS

Item 11 of the 2002-2004 Appropriations Act required a JCHC evaluation of the personal maintenance allowance (PMA) within the Medicaid Elderly and Disabled Waiver.

The Medicaid Program and Long-Term Care

When the Medicaid program was established in 1965, it was expected to provide health and nursing home care for low-income Americans; it is unlikely that the scope of Medicaid's current role in long-term care (LTC) was anticipated.

"Today, more than one-third of all Medicaid spending pays for long-term care (Kaiser 1997)….It is the largest source of financing for nursing home care, constituting 48% of payments (Levit et al. 1997). Medicaid is also a significant, though less dominant, source of funding for home care, paying for 14% of such services in 1996 (Levit et al. 1997)" from AARP *Medicaid Financial Eligibility for Older People*.

To qualify for Medicaid payment for LTC services a person must:

- Be aged, blind or disabled
- Comply with income and resource limitations
- Meet level of functioning criteria

Persons with incomes above the levels usually allowed for Medicaid may be eligible due to the cost of care

- In VA, the income level is set at 300% of SSI ($552 X 3 = $1,656) and "countable" resources are in general $2,000 for an individual and $3,000 for a couple.

Medicaid Waivers and the PMA

Medicaid waivers must be designed to allow individuals who would otherwise qualify for institutional placement (in a NF, ICF/MR or hospital) to remain in the community.

- PMA is the amount the waiver recipient is allowed to deduct from his/her income to account for the basic expenses related to living expenses.
- Additional deductions are allowed if the waiver recipient has un-reimbursed medical or remedial care expenses or a spouse or dependent children living in the home.

An AARP survey of the PMA within elder care waivers in 1998 showed:

- PMAs varied from $242 in NC to $1,482 in 14 states (NC increased its PMA to 100% SSI in 1999)
- the average PMA was $881 (178% SSI) and median PMA was $671 (136% SSI)

31 states allowed higher PMAs than VA in 1998.

VA has 6 Medicaid home- and community-based services (HCBS) waivers:

- Acquired Immunodeficiency Syndrome (AIDS); 417 inds
- Elderly and Disabled (E&D); 9,567 inds
- Consumer-Directed Personal Attendant Services (CD-PAS); 151 inds
- Individual and Family Developmental Disabilities Support (DD); 323 inds
- Mental Retardation (MR); 5,056 inds
- Technology Assistance; 280 inds

While income eligibility for each of the waivers is set at 300% of SSI, PMAs are set at 100% SSI except for the AIDS waiver.

Concerns with Costs of Living and the PMA

Advocates indicated that the PMA is not high enough for individuals who receive the Medicaid waivers (other than AIDS waiver).

In 2002, 3 Centers for Independent Living provided cost of living estimates for 1 disabled person:

- $1,914 per month in NOVA
- $1,247 per month in Norfolk
- $1,154 per month in far SW VA.

DMAS cost estimates to CMS showed that the waiver is less costly than NF care (FY 2001):

E&D Waiver - $14,856/ind; $141 million
NFs - $22,749/ind; $596 million

OPTIONS AND PUBLIC COMMENTS

In 2002, 44 comments were received from individuals and organizations.

Option I: Take no action.
No comments were received **in support of Option I**.

Note: The cost estimates for Options II and III were provided by DMAS in 2002. DMAS does not feel the estimates have changed significantly in the last year.

Option II: Introduce a budget amendment (language and funding) directing the Department of Medical Assistance Services to increase the personal maintenance allowance for the Elderly and Disabled waiver to one of the following levels:

A. 150 percent of Supplemental Security Income ($817.50) at an estimated GF cost of $1,018,800**;**

B. 200 percent of Supplemental Security Income ($1,090) at an estimated GF cost of $1,409,600**;**

C. 250 percent of Supplemental Security Income ($1,362.50) at an estimated GF cost of $1,509,220**;**

D. 300 percent of Supplemental Security Income ($1,635) at an estimated GF cost of $1,608,830**.**

Two comments were received **in support of Option II**.

Option III: Introduce a budget amendment (language and funding) directing the Department of Medical Assistance Services to increase the personal maintenance allowance for Medicaid HCBS waivers for the elderly and disabled, consumer-directed personal attendant services, mental retardation, and technology assistance to one of the following levels.

A. 150 percent of Supplemental Security Income ($817.50) at an estimated GF cost of $1,527,311**;**

B. 200 percent of Supplemental Security Income ($1,090) at an estimated GF cost of $2,166,351**;**

C. 250 percent of Supplemental Security Income ($1,362.50) at an estimated GF cost of $2,345,619**;**

D. 300 percent of Supplemental Security Income ($1,635) at an estimated GF cost of $2,524,885**.**

Forty comments were received **in support of Option III**.

Twenty-five comments specifically supported **Option III D**.

(The estimates provided by DMAS for Option III A-D do not include the costs associated with increasing the PMA for the Developmentally Disabled waiver because of delays experienced in getting this relatively new waiver program operating.)

Personal Care Rates

REVIEW OF STUDY FINDINGS

Medicaid personal care services assist elderly and disabled individuals with daily tasks which allow these individuals to live at home rather than in a much more costly institutional setting. The current Medicaid reimbursement rate for personal care services is $11.36 per hour for most areas of Virginia and $13.38 for Northern Virginia.

Personal Care Reimbursement Rates

A representative of the Virginia Association for Home Care (VAHC) and other representatives of the industry provided the Joint Commission with information concerning personal care services under the elderly and disabled waiver. The handout provided by VAHC indicated that there had been a decrease in personal care utilization by 10 percent and that the industry is "experiencing serious workforce shortages driven by a low reimbursement rate that puts them at a distinct personal care disadvantage in the health care labor market."

Home Care Representatives' Requests

The VAHC and Bill Axselle are requesting that JCHC and the General Assembly consider increasing the current reimbursement by four dollars per hour. Additionally, they are asking for budget amendment language that "requires DMAS to set forth the appropriate methodology for future reimbursement rate increases…once a more appropriate level of reimbursement had been established."

Although budget amendments requiring DMAS to develop a methodology for reimbursement were introduced in 1997 and 2000, these amendments were not included in the final budgets that were adopted.

OPTIONS AND PUBLIC COMMENTS

Option I: Take no action.

Option II: Recommend that JCHC introduce a budget amendment (language and associated funding) to increase Medicaid personal care reimbursement by $4.00 per hour. Estimated costs are $21,797,000 GFs for FY 2005 and $22,893,000 GFs for FY 2006.

Option III: Introduce a budget amendment (language and funding) to require the Department of Medical Assistance Services to develop a methodology for setting reimbursement rates for providers of personal care services on an annual basis.

JCHC Decision Matrix

- ❑ *Studies and Issues Considered by JCHC*
- ❑ *Recommendations of the Long-Term Care Subcommittee*
- ❑ **Recommendations of the Behavioral Health Care Subcommittee**

Review of DMAS Development of a Medicaid PDL

BACKGROUND

Item 325.ZZ of the 2003 Appropriations Act directed DMAS to establish a preferred drug list program for Medicaid by January 1, 2004. The Behavioral Health Care Subcommittee has received updates from DMAS on the progress of the program's development, as well as from Dr. Randy Axelrod, Chairman of the Pharmacy and Therapeutics Committee and from Karen Saunders of the American Psychiatric Association.

RECENT ACTIONS

A Pharmacy and Therapeutics Committee (P&T Committee), appointed by the Secretary of Health and Human Resources, established a two step review process. "The first step is that the committee will determine based on clinical evidence, whether a therapeutic class or a subset of that class is eligible for the PDL program. The second step will be for the P&T Committee to review the supplemental rebates offered by the pharmaceutical companies for the therapeutic class under review and determine which drugs meet both the clinical requirements and the 'best' price."

DMAS has established a PDL Implementation Advisory Group including "representatives of pharmaceutical manufacturers, providers and advocates… [to] provide advice to the agency regarding implementation of the PDL program. It is anticipated that the advisory group will be of particular assistance in the areas of provider/consumer education, and reviewing the process for prior authorization of non-preferred drugs and prior authorization for 'more than nine unique prescriptions.'"

With regard to the primary classes of concern for the Joint Commission on Health Care, DMAS has excluded anti-psychotics from the PDL process. However additional classes of drugs such as anti-depressants have not been reviewed. Certain classes of drugs such as anti-depressants will not be considered prior to January 2004 given the phased-in process being used by the P&T Committee in its deliberations.

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

Written comments from interested parties regarding the development of a preferred drug list for Virginia Medicaid to allow for review prior to reporting to the Joint Commission on Health Care during the November 12th meeting. *(Former Options II and III.)*

Continue to address the issue of development of a preferred drug list for Medicaid by including the issue in the Subcommittee's workplan for 2004. *(Former Option IV.)*

One comment was received **in support of this Option**.

Voices for Virginia's Children

OPTIONS RECOMMENDED FOR JCHC REVIEW

Option I: By letter, from the Chairman of the Joint Commission on Health Care express the concerns of the Joint Commission regarding the inclusion of anti-depressants in the Preferred Drug List Program for Medicaid. The letter should include:

- an explanation that the Joint Commission is not mandating inclusion of anti-depressants on the Preferred Drug List for Medicaid,
- a request that any decision regarding inclusion of anti-depressants be based on medical judgment rather then budgetary considerations, and
- and a request to delay implementation of any action to include anti-depressants within the Preferred Drug List Program until at least July 1, 2004, to allow members of the General Assembly an opportunity to review and comment on the proposal.

A copy of the letter would be sent to the Department of Medical Assistance Services and members of the House Appropriations Committee and the Senate Finance Committee. *(Former Option V.)*

Four comments were received **in support of this Option.**
National Mental Health Association and Mental Health Association of Virginia, Psychiatric Society of Virginia, Virginia Association of Community Services Boards, and Voices for Virginia's Children

Three comments were received **in support of the introduction of legislation to exclude anti-depressants from the Medicaid PDL**.
National Mental Health Association and Mental Health Association of Virginia, Psychiatric Society of Virginia, and Voices for Virginia's Children

One comment was received **in support of "greater input and protocol development by the newly-formed PDL Advisory Committee regarding:**

- **An expedited Prior Authorization process for any drug not on the PDL for consumers with mental illness and/or mental retardation case managed by CSBs;**
- **Expedited authorization for consumers with mental illness and/or mental retardation who are prescribed above nine (9) unique prescription drugs. Withholding medications from these very vulnerable individuals may place them at risk for more expensive care."**

Virginia Association of Community Services Boards

Cross-Training and Innovative Practices

STATUTORY BASIS

SJR 97/HJR 142 (2002) requested that DMHMRSAS (1) develop and advise on implementation of "a curriculum for cross-training law enforcement officers, judges, jail and detention home staff, and community mental health treatment staff in security and treatment services" and (2) to explore and recommend options for communicating "information about innovative practices among providers of mental health and substance abuse treatment services to offenders."

RECENT ACTIONS

Cross-Training Curriculum

A preliminary framework for cross-training curricula that "articulate[s] the specific 'core competencies' needed…to provide the most appropriate response to persons with mental illness, mental retardation and substance abuse in a criminal justice setting" has been developed. Additional input is being submitted on behalf of Sheriffs, Police Chiefs, Commonwealth's Attorneys, and Public Defenders. DMHMRSAS recommends that once the curriculum has been completed, it should be used as a "framework for evaluating and developing training for state and local treatment and criminal justice personnel [and to] develop strategies, including statutory proposals if appropriate, to strengthen state and local interagency relationships to enhance cross-training efforts…."

Dissemination of Innovative Practices

DMHMRSAS plans to include innovative practices as a resource in its web-based site for evidence-based, best, and promising practices. That website is being developed for use by practitioners, consumers, families and others. In addition, DMHMRSAS will continue to work with other entities, such as the UVA Institute of Law, Psychiatry and Public Policy, regarding collaboration in designing or providing links to the innovative practices resource.

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

By letter from the Subcommittee Chairman, request DMHMRSAS continue to address inclusion of innovative practices within its web-based site for evidence-based, best, and promising practices. Include in the letter, a request that DMHMRSAS report to the Subcommittee on its progress prior to the 2005 General Assembly Session. *(Former Option VI).*

Continue to address the issue of dissemination of innovative practices by including the issue in the Subcommittee's workplan for 2004. *(Former Option VII).*

OPTIONS RECOMMENDED FOR JCHC REVIEW

Option I: Introduce legislation to amend the *Code of Virginia*, § 9.1-102.2 to require by July 1, 2005 that the Department of Criminal Justice Services ensure a training curriculum is available that provides basic knowledge, skills and abilities to assist in understanding and working with individuals who have mental health and/or substance abuse disorders. The training is to be phased in over a two year-period to be incorporated into the compulsory minimum training standards required for law enforcement officers and for medical personnel working in local and regional jails and secure detention facilities. *(Former Option II).*

***Option II**: Continue to address the issue of cross-training curriculum by including the issue in the Subcommittee's workplan for 2004.*

Evaluation of Mental Health and Substance Abuse Programs for Offenders

STATUTORY BASIS

SJR 97/HJR 142 (2002) requested that the Secretary of Public Safety and the Secretary of Health and Human Resources delineate a plan "for collecting data on treatment services provided to and needed by state responsible offenders and a process for evaluating the effectiveness of treatment services."

RECENT ACTIONS BY PUBLIC SAFETY

Department of Corrections (DOC)

DOC does not comprehensively evaluate the effectiveness of behavioral health care programs provided for offenders. In fact, budget and staff reductions have "impeded [DOC's] ability to evaluate programs" except on a limited basis. DOC's mental health units and sex offender treatment program are licensed by DMHMRSAS and the Marion Correctional Treatment Center is accredited by JCAHO. Furthermore, DOC is implementing improvements that will enhance the agency's ability to evaluate programs.

- DOC and VCU have a MOA "to develop a prioritized list of evaluation needs."
- An automated Offender Management System that will allow for better tracking of offenders over time will be developed according to funding availability.
- Future DOC reports on behavioral health care programs for offenders will include licensing, certification, accreditation and inspection status of the programs.
- Planning and funding for evaluating programs will need to be included in future program development plans.

Department of Juvenile Justice (DJJ)

DJJ does not comprehensively evaluate the effectiveness of behavioral health care programs provided for juvenile offenders. However, DJJ maintains a Juvenile Tracking System which in concert with criminal record checks by the State Police, allows for monitoring of recidivism. DJJ institutions are required to meet VA CORE standards for children. Moreover, DJJ programs are:

- Provided by trained and credentialed personnel.
- Designed based on programs that have been effective in other states.
- Assessed on a periodic basis against established treatment standards.
- Improved using a "'self-adjusting' process as new program knowledge and research become available."

Evaluation of Mental Health and Substance Abuse Programs *cont.*

Public Safety Evaluation Opportunities

Public safety agencies are considering a number of ways of improving the evaluation of treatment programs for offenders including:

- Incorporating evaluation requirements and funding in future programs.
- Improving agency data systems so that data can be provided in the future.
- Pursuing funding for evaluations from sources other than the State.
- Looking to establish additional partnerships with academic institutions to conduct evaluations.

RECENT ACTIONS BY BEHAVIORAL HEALTH ENTITIES

DMHMRSAS staff indicated that in general, the available information relates to access, utilization, and adequacy of programs rather than outcome measures.

Inpatient Forensic Services

The DMHMRSAS inpatient treatment programs are accredited by JCAHO. The **number of transfers** from correctional facilities into inpatient forensic programs in 2003 and the **average waiting periods** for those transfers were reported to be:

- 136 transfers for evaluation of trial competency, sanity, sex offenses, pre-sentencing, etc. – 26.3 days
- 416 transfers for intensive treatment – 3.6 days
- 285 transfers for competency restoration – 50 days.

DMHMRSAS has contracted with the Institute of Law, Psychiatry, and Public Policy at UVA to provide training in forensic evaluation in order to increase the number of forensic services that can be provided in a correctional facility or in the community. DMHMRSAS estimated that the 1,664 community-based evaluations completed in FY 2003 at a cost of $547,000 saved the Commonwealth nearly $25 million in what inpatient evaluations would have cost. An additional $2 million was estimated in savings related to the provision of restoration to competency services to juveniles on an outpatient basis (DMHMRSAS estimate).

CSB-Provided Forensic Services

CSBs provide services to adult and juvenile offenders on the basis of performance contracts and agreements with DMHMRSAS and agreements made directly with the local correctional entity. CSBs reported on treatment provided for more than 14,000 offenders in FY 2002. An August 2003 survey of probation and parole offices in Virginia indicated, "crisis intervention, case management, individual and group counseling, and psychotropic medication treatment are available through local mental health agencies in most locales in the state." However, "there is often a significant wait for access to all these services, except for crisis intervention. Waiting times can range up to 120 days for enrollment in various forms of outpatient counseling, in some jurisdictions."

Evaluation of Mental Health and Substance Abuse Programs *cont.*

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

By letter from the Subcommittee Chairman, request that the Secretary of Public Safety and the Secretary of Health and Human Resources continue to collaborate to develop a plan "for collecting data on treatment services provided to and needed by state responsible offenders and a process for evaluating the effectiveness of treatment services." *(Former Option II.)*

By letter from the Subcommittee Chairman, request the Department of Mental Health, Mental Retardation and Substance Abuse Services work with the Virginia Supreme Court to develop a system for reporting non-confidential information regarding the types of forensics evaluations that are reimbursed by the Court. *(Former Option IV.)*

Continue to address the issue of evaluation of mental health and substance abuse by including the issue in the Subcommittee's workplan for 2004. *(Former Option V.)*

OPTIONS RECOMMENDED FOR JCHC REVIEW

Option I: Introduce a budget amendment (language only) that requires any new mental health or substance abuse treatment initiatives for offenders to include an evaluation and reporting component. *(Former Option III.)*

Uniform MH Screenings in Secure Detention Facilities

STATUTORY BASIS

SJR 97/HJR 142 (2002) requested DJJ "to design and implement a uniform mental health screening instrument and interview process of juvenile offenders admitted to secure detention facilities….."

RECENT ACTIONS

DJJ convened a workgroup in 2002 that designed an interview protocol and selected the Massachusetts Youth Screening Inventory, Second Version or MAYSI-2 as the uniform screening instrument to be used by the 24 secure detention facilities. DJJ also modified its statewide automated detention home data system to incorporate the MAYSI-2 information.

The interview protocol and screening instrument were implemented on March 1, 2003, with no significant problems being reported to DJJ by detention facilities. In a short period of time however, several detention facilities contacted DJJ staff to report that "they would be unable to continue to enter the MAYSI-2 data into the automated data system due to the new requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) regulations….HIPAA regulations greatly limit the sharing of personal health information, such as MAYSI-2 results, and city and county attorneys in the jurisdictions of the detention facilities are advising them not to enter this information into the automated system."

DJJ reports that as of July 1st, screening "results for 2,504 juveniles were entered into the automated DJJ data system by 18 of 24 detention facilities since March 1. However, at that time, only seven facilities continue to enter MAYSI-2 results into the automated system."

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

By letter from the Subcommittee Chairman, request that beginning in FY 2005, DJJ submit annual reports to the Subcommittee of aggregated results and any analysis of the reporting submitted by secure detention facilities of MAYSI-2 information. *(Former Option III.)*

Continue to address the issue of the uniform mental health screenings in secure detention facilities by including the issue in the Subcommittee's workplan for 2004. *(Former Option IV.)*

OPTIONS RECOMMENDED FOR JCHC REVIEW

Option I: Introduce legislation to amend *Code of Virginia* § 16.1-248.2 to require secure detention facilities to use a DJJ-approved uniform mental health screening assessment and to enter the screening results into the DJJ automated Juvenile Tracking System. *(Former Option II.)*

Recommendations of the Adult and Juvenile Offender Workgroups

STATUTORY BASIS

SJR 97/HJR 142 (2002) continued the study (originally authorized by SJR 440 in 2001) of treatment options for offenders who have mental illness or substance abuse disorders. The SJR 97/HJR 142 study was undertaken by the Joint Commission on Behavioral Health Care in conjunction with the Commission on Youth and staff assistance from the Division of Legislative Services and assumed by the Joint Commission on Health Care on July 1, 2003.

RECENT ACTIONS

An adult offender workgroup and a juvenile offender workgroup including a number representatives of state, local and private entities from the behavioral health, human resource, and public safety arenas have worked diligently for three years. Recommendations have been made in the areas of diversion from the criminal justice system when possible, enhanced services for offenders who have mental illness or co-occurring disorders who are incarcerated in local and regional jails, and enhanced assistance when these offenders are released from jails or prisons.

RECOMMENDATIONS OF THE ADULT OFFENDER WORKGROUP

Diversion from Jail

The workgroup noted that there are a number of ways in which adults who suffer from mental illness could be diverted from local and regional jails. In the short-term, diversion would require funding for start-up costs. However, diversion is expected to generate significant savings in the long-term in both financial and human costs. The intent is to help to prevent "the criminalization of mental illness."

Service Provision in Jail

The workgroup recommended enhancing the ability of regional and larger jails to develop specialized programs to allow the opportunity for smaller jails to transfer inmates for needed services. The idea is to provide for enhanced reimbursement for approved transfers.

Reentry Assistance Prior to and Upon Release

Correctional facilities (larger jails and prisons in particular) may want to identify contacts and establish agreements with social services agencies, CSBs, and the federal Social Security Administration to assist with reentry issues.

Additional Recommendations

By letter from the Subcommittee Chairman, emphasize the need to address in planning for reinvestment and in restructuring the impact of proposed actions on the criminal justice system. In addition, to work closely with the Forensics Special Populations Work Group and regional restructuring entities to ensure that the potential/actual offender population is considered and addressed.

RECOMMENDATIONS OF THE JUVENILE OFFENDER GROUP

Diversion from Secure Detention Facilities

The juvenile justice system provides for many opportunities for diversion from the system. The workgroup members indicated juveniles who have emotional disturbance comprise the largest group who could be safely diverted from secure detention if alternatives were provided. These children are often difficult and disrespectful and if labeled "delinquent" are at real risk of being "criminalized."

Service Provision in Secure Detention and Reentry Assistance Upon Release

DCJS awarded just under $495,000 in a one-year grant to DMHMRSAS to develop a model for the provision of mental health services in secure detention and case management services upon release from detention. DMHMRSAS will be working with CSB staff to provide services to juveniles who are confined and in some cases being released from five secure detention facilities.

Chesapeake CSB and Tidewater Detention Home
Crossroads CSB (Farmville area) and Piedmont Regional Detention
Planning District One BH Service and Highlands Juvenile Detention Center
Richmond Behavioral Health Authority and Richmond DJJS
Valley CSB (Staunton area) and Shenandoah Valley Detention Center

The workgroup considered this grant to be an important opportunity to learn from the experience in these 5 detention centers.

Additional Recommendations

By letter from the Subcommittee Chairman, emphasize the need to consider and address in planning for Item 329G initiatives, the impact of proposed actions on the juvenile justice system. The intention is to work closely with the Item 329G work group to ensure that the potential/actual juvenile offender population is considered and addressed.

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

Include in the 2004 Subcommittee workplan the specific issue of working with the local and regional jail administrators and associations, the Compensation Board, Community Services Boards and their association, and DMHMRSAS regarding the idea of enhancing the ability of regional and larger jails to develop specialized behavioral health programs that could be resources for inmates of jails that lack such programs. *(Former Option IV.)*

By letter from the Subcommittee Chairman emphasize the need for DMHMRSAS to consider the needs of offenders with mental illness and/or substance abuse disorders in regional reinvestment plans and in restructuring. *(Former Option V.)*

Continue to address the issue of treatment options for adult and juvenile offenders who have mental illness or substance abuse disorders by including the issue in the Subcommittee's workplan for 2004. *(Former Options VI and X.)*

By letter from the Subcommittee Chairman emphasize the need for the planning group for Item 329.G. to consider the needs of juvenile offenders in planning for behavioral health care services for children, adolescents, and their families. *(Former Option XI.)*

OPTIONS RECOMMENDED FOR JCHC REVIEW

Option I: Introduce a budget amendment (language only) to express support by the Joint Commission on Health Care to continue State funding of local initiatives to address the needs of adults and juveniles with mental health and substance abuse disorders who come into contact with the criminal justice system. Examples of initiatives include drug courts, therapeutic programs both in the community and within jails and secure detention facilities, and specialized probation and parole supervision. (*Former Options II and VIII.)*
One comment was received **in support of this Option.**
Virginia Association of Community Services Boards

Option I: *(Alternative Language)* Introduce a budget amendment (language only) to include a statement of support by the Joint Commission on Health Care for programs designed to divert (when possible) or to provide services addressing the treatment needs of adults and juveniles with mental health and substance abuse disorders who come into contact with the criminal justice system. Examples of initiatives include drug courts, therapeutic programs both in the community and within jails and secure detention facilities, and specialized probation and parole supervision. (*Former Options II and VIII.)*

Option II: Introduce a budget amendment (language only) to provide non-financial assistance in developing demonstration projects designed to divert from jail or secure detention, individuals exhibiting mental illness (including co-occurring disorders) who have committed an offense (that is not a serious violent or destructive act) that, if properly assessed and treated, would predictably reduce or eliminate the re-occurrence of such offenses. *(Former Options III and IX.)*

Discharge Planning for Adult Offenders

STATUTORY BASIS

SJR 97/HJR 142 (2002) requested that DOC and DMHMRSAS "examine ways to ensure offenders' access to appropriate medications and the management of medications for offenders when they are released from state correctional facilities. The Departments shall include in their recommendations the contents required in a memorandum of agreement to ensure continuity of care for offenders in post-incarceration status."

RECENT ACTIONS

A preliminary memorandum of agreement (MOA) has been developed with representatives of DOC, DMHMRSAS, and several CSBs. The agreement delineates agreed upon actions on the part of DOC, CSBs, and DMHMRSAS with regard to assisting offenders with mental health and/or substance abuse disorders transition back into the community upon release from DOC. In developing the MOA, funding and staffing constraints were not considered. Instead, the agreement presents a model for what the various entities could work together to accomplish.

The memorandum has been approved by DOC, but is still under review by DMHMRSAS and the CSBs. Initial comments provided by CSBs regarding the provisions of the MOA indicate that there are significant concerns that need to be resolved.

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

By letter from the Subcommittee Chairman, request that the Department of Corrections, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the community services boards continue to develop the memorandum of agreement and report to the Subcommittee prior to the 2005 General Assembly Session. *(Former Option II.)*

One comment was received **in support of this Option.**

Virginia Association of Community Services Boards

Continue to address the issue of providing assistance for offenders who are being released from local and state correctional facilities in receiving federal and state benefits (such as Social Security benefits and Medicaid) by including the issue in the Subcommittee's workplan for 2004. *(Former Option III.)*

One comment was received **in support of this Option.**

Virginia Association of Community Services Boards

Access to Medicaid for Offenders

STATUTORY BASIS

SJR 97/HJR 142 (2002) requested that DMAS, DOC, and DJJ "examine ways to provide immediate access to Medicaid benefits for eligible offenders when they are released from prisons, jails, juvenile correctional centers or detention homes."

RECENT ACTIONS

It has been the general policy of the federal government that federal money will not be provided for services for "inmates of public institutions" such as correctional facilities (*Code of Federal Regulations*, Title 42-435.1008). Recently, questions have been raised regarding this policy, in part because of an understanding that as many as three states may have received reimbursement through Medicaid for medical care for their incarcerated inmates. A related issue is whether Medicaid eligibility should be suspended or terminated for offenders when they are incarcerated.

DMAS staff addressed these issues and indicated the following. First, the DMAS regional contact for the Centers for Medicare & Medicaid Services stated that a letter should be forthcoming from Mr. Dennis Smith clarifying the guidelines for Medicaid coverage for incarcerated offenders. The letter is expected to say that in general incarcerated offenders are not eligible for Medicaid enrollment. However, DMAS staff indicated that if Medicaid reimbursement for the incarcerated population were allowed explicitly by CMS without negative consequences (such as making changes in the program that ultimately would be more expensive for the Commonwealth), Virginia would favor that reimbursement. Second, in terms of suspending benefits, DMAS staff believe that very few offenders would be eligible for suspension of benefits, even if that were an option Virginia chose to pursue. The basis for Medicaid eligibility for the majority of adult offenders prior to being incarcerated would have been eligibility for Supplemental Security Income (SSI). However, upon incarceration, these offenders would lose their SSI eligibility which would require DMAS to terminate their eligibility for Medicaid as a SSI recipient. Similarly, the basis for Medicaid eligibility for the majority of juvenile offenders prior to being confined would have been related to their "status" in terms of being in foster care or a member of a low-income household. Again, loss of that "status" on the basis of criminal charges or conviction would typically require DMAS to terminate Medicaid eligibility. Exceptions are made for juveniles who are held in secure detention for certain reasons other than criminal charge such to protect the juvenile or because detention is considered to be in the best interest of the juvenile.

Actions have been taken to ensure that offenders who have mental health or substance abuse disorders and are being released from jails and correctional facilities are assisted. These actions include:

- "DSS Medicaid eligibility manual was revised to provide specific instruction to local Departments of Social Services on accepting and processing applications for incarcerated individuals who are about to be released."
- Local DSS staff have been trained regarding the policy changes and have received a Medicaid Fact Sheet that addresses eligibility for offenders who are being released from local and state correctional facilities.
- DMAS is also working with DOC and others to distribute the Medicaid Fact Sheet and Medicaid applications to state correctional facility staff, probation and parole officers and local and regional jails.
- DMAS intends to continue to monitor how the application process is going and to "offer technical assistance when necessary to facilitate inmate access to Medicaid coverage."

BEHAVIORAL HEALTH CARE SUBCOMMITTEE ACTIONS

By letter from the Subcommittee chairman, request that Department of Medical Assistance Services report to the Subcommittee regarding any changes in federal interpretation of Medicaid regulations and that DMAS and the Department of Corrections report on how the processing of offender applications for assistance is working. *(Former Option II.)*

Continue to address the issue of offender access to Medicaid benefits by including the issue in the Subcommittee's workplan for 2004. *(Former Option III.)*